New Accountabilities for Health Gain

Strategies for Improving the Performance of
The Russian Health Sector Inorder
To Protect and Enhance the Rights of 140 million Russian Citizens and
Two million Health Sector Workers as
Russia Prepares for the 21st Century

A Concept Paper

Developed by Team of Russian-American Experts Within
The ZdravReform Program
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Traditional Goals, Non-traditional Strategies to Achieve These Goals:

Russia contains approximately 140 million citizens and 2 million health sector workers who deserve the most creative and active search for practical strategies to strengthen and enhance the performance of the Russian health sector. Improving the performance of the Russian health sector requires all parties to accept new accountabilities to the public and to each other. The parties that must be more accountable, more transparent in their work and results are: physicians, hospitals, insurance companies, territorial insurance funds, oblast health committees, the Ministry of Health, and the citizens.

For over two years, a unique team of Russian-American health policy experts have been living and working in the Russian health sector; a health sector that is experiencing the dramatic changes caused by the landmark legislation of 1991 and 1993. This cross-national team has not been satisfied to rely upon traditional strategies from either Russia or the United States; rather, they have sought to explore and adapt innovative strategies for health sector performance improvement from several countries in order to avoid the weaknesses of both the US and the Russian health sectors.

This paper seeks to answer the following strategically important questions related to improving the performance of the Russian health sector for 21st Century health care and health gains:

What is "Performance Improvement" in the Russian health sector?

Why does the Russian health sector need "Performance Improvement"?

What strategies should be implemented to increase the probability that health sector performance improvement can occur within the next three-five years?

In the process of cross-national research abroad; testing of new ideas in pilot projects within rayons and oblast of Russia; and the examination of what is politically and economically possible in the current Russian reality, the ZdravReform Russian-American team has reached the following conclusions which are further developed in this Concept Paper and its attachments:

Conclusion 1: Even with the positive changes since 1991, the Russian health sector is still not performing well enough. There are a number of symptoms that the health sector faces large challenges. (See Exhibit 1)

There are three (3) fundamental problems with the performance of Russian health sector.

Conclusion 2: There should be three (3) major goals of the Russian Health Sector.

Conclusion 3: There are three (3) major principles that should guide all efforts to (a) remove the obstacles to problem solving; (b) use resources more cost effectively to enhance the nation's health.

In addressing these three problems, three goals and three principles, ten (10) strategic initiatives have been identified as crucial to improving the performance of Russian health sector.

EXHIBIT 1: Overview of Russian Health Sector Reform Challenge

3 SYMPTOMS OF WEAK PERFORMANCE

1. Russian life expectancy has slipped to one of the lowest levels in the world;

2. Citizen satisfaction with the value received from the health sector is very low; and

3. Resource levels for the health sector are tragically and paradoxically low and not well utilized.

3 GOALS FOR PERFORMANCE IMPROVEMENT

1. Improve life expectancy through bold investments for "health gain" activities by individuals and enterprises;

2. Improve citizen satisfaction with the Russian health sector by increasing the responsiveness of health sector institutions and workers to the needs of Russian citizens for quality service and cost effective health outcomes; and

3. Attract and better manage more resources into the health sector through new mechanisms of social welfare and tax policy and modern financial management.

3 PRINCIPLES TO GUIDE STRATEGIES FOR GOAL ACHIEVEMENT

1. *Health gain* requires new risk management strategies and responsibilities by all; responsibilities that are defined in a transparent, new "Social Compact for Health";

2. There must be redefinition and rebalancing of the degree of sensible decentralization of controls over the delivery and financing of health services; and

3. Economic flows to and within the health sector must rely upon a new mix of regulations and market forces to achieve the most cost effective return on the society's investment of its scarce resources into the Russian health sector.

Initiatives and mechanisms needed to implement these principles are described in the following pages of this "Concept Paper" and its two attachments.

What is "Performance Improvement" in the Russian Health Sector?

Performance Improvement requires Russian health policy leaders to reform their attention on a series of bold initiatives designed to improve both (a) the quality of health status of Russian people, and (b) the cost effective use of health resources to achieve the population's collective state of well being. Examples of partial measures of better performance are:

- less morbidity/mortality
- more money in system
- more salary for doctors and nurses
- more patient satisfaction
- better access to primary care physicians
- less hospital capacity in order to reallocate funds to primary care and to health promotion
- more primary care reliance at new general practice offices within and outside polyclinics
- enough X-Ray film to do diagnosis
- more doctors and nurses that smile
- senior doctor that knows more about the patient receiving surgery
- doctors and nurse supervisors that do not take bribes

Why does the Russian health sector need "Performance Improvement"?

New strategies and mechanisms are needed to improve the performance of the Russian health sector because life expectancy is embarrassingly low; public opinion polls show that citizens do not value the health care system; and the health entangled in a paradox of neither having enough money, nor using the money it has in the most cost effective ways.

What strategies should be implemented to improve the performance of the Russian Health Sector?

There are ten (10) "Strategic Initiatives" that need to be implemented in a series of new laws, regulations and programs during 1996-1997. These initiatives are listed on the next page. Mechanisms needed to implement each of the "Strategic Initiatives" are then defined in the pages following the list. Further narrative discussion of the rationale for these "Strategic Ten Initiatives" is provided as background reading for policy makers in the two attachments to this "Concept Paper." All of these initiatives are designed to increase the visibility and parties working in the Russian Heath Sector.

Ten (10) Strategic Initiatives

are proposed to Overcome the Cited Symptoms, to Achieve the Goals, and to Enhance the Principles of Russian Health Sector Performance Improvement:

1. Encourage and support citizens and enterprises to avoid risks of poor health in order to reduce the need to enter the health care system;
2. Establish an explicit "Charter of Patient Rights and Responsibilities" once they enter the health care system;
3. Establish a "New Federalism", a new balance of Federal and Territorial Responsibilities for health sector management;
4. Revise the sources of funding the health sector by integrating taxes for budget and insurance funds, and add dedicated excise taxes on tobacco and alcohol, rely more on point of service copayments by patients who can use their receipts for such payments to receive tax credits;
5. Build closer coordination between health insurance and social welfare insurance;
6. Encourage the development of not-for-profit "Medical Trusts" to allow communities to better manage their health institutions' assets in the public interest;
7. Move beyond Medical Economic Standards (MES) to implement new managed care and evidence based quality improvement programs in hospitals and polyclinics, and reinforce contract language from compulsory insurance programs to require more explicit actions for quality outcomes;
8. Attract new capital for health sector infrastructure improvements through new "Health Security Bonds";
9. Revitalize a reliance on "population based" regional health planning for the better use and deployment of infrastructure and technology inorder to:
    - encourage restructured polyclinics that have new General Practice offices;
    - establish integrated systems of health service delivery and finance within oblasts and rayons; and
    - reduce unneeded hospital capacity with special new funds for retraining displaced health workers;
10. Establish new information systems for local health institutions and insurance companies or Territorial Funds, at both oblast, and federal levels in order to generate statistics needed for better reporting to the public, enterprises and international health organizations regarding health sector quantity, quality, and cost performance.

Initiative 1: Encourage and Support Citizens and Enterprises to avoid risks of poor health in order to reduce the need to enter the health care system:

Strategies to Achieve Initiative:

1. The Ministry of Health should establish a new "National Health Advisory Council" to provide measurable goals and plans of action to improve the health status of the nation. This National Health Advisory Council would draw upon recent advances in public health planning and health status enhancements in Western Countries. This Council would be broadly representative of Russian citizens, enterprises, physicians,

hospitals and health insurance perspectives. The Council would publish annual reports on the health of Russia, plans to improve the Health of Russia, and progress being made to improve the health of Russia, and progress being made to improve the health of Russia, and progress being made to improve the health of Russia.

2. Enact and enforce stronger laws to encourage health behaviors:
   2.1 Stop smoking in all public areas and lobbies of buildings;
   2.2 Illegal to advertise tobacco products on TV, public billboards, radio or magazines;
   2.3 Illegal to sell tobacco to persons under age 18;
   2.4 Illegal to sell alcohol to persons under age 21;
   2.5 More enforcement of seat belts in automobiles;
   2.6 More enforcement of driving while intoxicated laws;
   2.7 Adopt workplace and occupational health and safety regulations that parallel those in Western Europe.
3. Provide tax credit to enterprises that invest in certain Ministry of Health approved health promotion programs and workplace safety programs;
4. Increase requirements of television channels to provide a defined minimum level of "Public Service Announcements" (PSAs) by charitable organization that motivate citizens to pursue healthier lifestyles;
5. Provide tax credits to investors and Non-Governmental Organizations (NGOs) who provide funding for certain Ministry of Health endorsed health education and fitness programs, and/or who provide PSAs to local TV stations that are positive and professional attempt to encourage healthier lifestyles.
6. Expand health education within elementary schools to encourage healthier lifestyles regarding smoking, drinking, nutrition and fitness.
7. Enact laws that encourage greater reliance on Primary Care Physicians, e.g. change funding of medical schools to a per student basis with more subsidies for students who train to be general practitioners; offer tax credits for doctors who establish private practices that promote healthier lifestyles; and encourage insurance companies and territorial health insurance funds to use capitation payments that give physicians an economic incentive to keep their patients healthy.
8. The Minister of Health should provide significant publicity to and a cash award for the five health care organizations, public or private, that are recognized as doing the most effective work to encourage healthy lifestyles and healthy cities in keeping with WHO guidelines. The "Annual Health Promotion Awards Ceremony" should also provide special recognition for enterprises with excellent safety records, cities who demonstrate advances in health status, and citizens who deserve special recognition for serving as role models of excellent healthy lifestyles.

Initiative 2: Establish an explicit "Charter of Patient Rights and Responsibilities"

Strategies to Achieve Initiative:

1. Ministry of Healthy to form National Advisory Committee on Patients Rights. This panel would manage process to define ideal "Patients Charter" before June 1997. The charter is to be posted in all lobbies and public areas of all hospitals and polyclinics.
2. Enact law enabling citizens to bring civil law suit against a physician or hospital which performs inappropriate acts that cause material harm to patient; this law suit and/or arbitration by an administrative judge could yield substantial financial penalties to the doctor and hospital. British law could be studied for application in Russia.
3. Ministry of Health provides annual cash awards to 10 most effective hospitals and 10 most effective polyclinics with highest patient satisfaction scores on standardized questionnaire.

Initiative 3: Establish a "New Federalism", a new balance of Federal and Territorial Responsibilities for health sector management.

Strategies to Achieve Initiative:

1. Enact regulations that reverse some of the decentralization of public health promotion and protection services from rayons and municipalities back to the oblast committees. The oblast are to have expanded ability to levy taxes for strengthening local health enhancement programs and services;
2. The Ministry of Health becomes responsible for sanitary and epidemiology activities, and has broader powers during the next 5 year to offer model regulations and training programs for use by local governments for:
   - air quality
   - water quality
   - sanitary servers
   - restaraunt inspection
   - occupational health and safety
   - hazardous waste disposal
   - environmental pollution
3. Compulsory Health Insurance encouraged to continue, but with certain regulatory refinements:

Federal Fund expands its role as:

- Regulator of Private Insurance Companies;
- Research and Development into Strategies and systems for improved provider contracting, actuarial studies of cost, and quality of care;
- Provides actuarially designed reinsurance and loss insurance for Territorial Funds and Private health insurance companies;
- Educator and licenser of insurance industry managers actuaries and economists;
- auditor of territorial funds and private insurance companies;
- Reports on funds flows within the health sectors of each oblast and the country as a whole.

Initiative 4: Revise the Sources of Funding for Health Sector by three funding strategies: Integrating taxes for budget and insurance funds; add dedicated excise taxes in tobacco and alcohol; and rely more upon "Point-of-Service" (POS) copayments by patients who can use their receipts from doctors and hospitals for tax credits.

Strategies to Achieve Initiative:

1. Integrate Traditional Budget funds with Insurance Funds via:
    - Reduce social welfare taxes by 5% and add this to current 3.6% for a new dedicated total of 8.6% of wages;
    - The oblast government is obligated by law, and risk of fine or loss of Federal tax revenues, to pay a fixed per capita "premium" per month to the Territorial Health Insurance Funds for each person eligible for such subsidy. Eligibility for this subsidy is dependent on the person falling below a Federally defined "level of poverty";
    - The Federal Fund is obligated to assemble data and report to the public and Parliament the oblast specific funds flows resulting from the above policies, and to conduct such actuarial studies as needed to continuously evaluate the adequacy of the above funding sources, and these defined below in strategies 2 and 3;
2. Add new dedicated excise taxes on alcohol and tobacco:
    - An additional tax of 2% added to the sale of all cigarettes and tobacco products, as well as to all retail and wholesale alcohol sales.
    - Collected as in part, but with monthly funds transfers to the Ministry of Health for use to Fund health promotion and health protection services; and
    - Annual reports to the public on sources and uses of those funds.
3. Greater use of "Point-of-Service" (POS) copayments by patients who can use their receipts for a tax credit.
    - National guidelines for which services are to receive which copayments are to be prepared by a National Health Council staffed by the Ministry of Health. Final copayment levels can be decided, however, by oblast Health Care Committees;
    - CoPayments collected, retained, and reported as taxable income to doctors and hospitals; and
    - Receipt issued to patients reported as tax credit according to procedures defined jointly by The Ministry of Health, Federal Fund and Ministry of Finance.

Initiative 5: Build Closer Coordination Between Health Insurance and Social Welfare Insurance.

Strategies to Achieve Initiative:

1. Convene a Federal-Oblast level Task force to study and report within six months the scope and nature of funds flow and services provided within health sector versus welfare or social support services.

2. Fund pilot projects in 3 oblasts to define practical ways to integrate funding and services of sickness-health insurance and budgetary funds for various welfare services to vulnerable segments of the public.
3. Draft model legislation for oblasts to have new flexibility and economic incentives to encourage more cost effective coordination among social service and health service providers and insurers.

Initiative 6: Encourage the Development of not-for-profit "Medical Trusts" that allow communities to better manage their institutions' assets in the public interest.

Strategies to Achieve Initiative:

1. Enact legislation allowing oblasts and municipalities to transfer control of hospitals and polyclinics to a new legal entity formed not as a private commercial enterprise, but as a non-governmental, not-for-profit body that owns and manages assets on behalf of the public, i.e. Board appointed to represent the broad public interest and which must report on all of its plans, activities, results and financial affairs to the public and to the oblast administration.
2. Provide special tax advantages, i.e. reductions, for those Medical Trusts that meet certain performance guidelines defined by the Ministry of Health; and
3. Develop and fund a special Federal level training and advisory support program to municipalities to help form, and then to operationalize these "Medical Trusts". This support program would be only authorized to exist for a period of five (5) years.

Initiative 7: Move Beyond Medical Economic Standards (MES) to Implement Evidence Based Quality Improvement Programs in Hospitals and Polyclinics.

Strategies to Achieve the Initiative:

1. Establish a Federal Committee on Accreditation of Quality Improvement to design and periodically evaluate quality of care indicators for licensing and accrediting hospitals and polyclinics. The Committee would have representatives from the Ministry of Health, The Federal Fund, and selected medical societies and post graduate research and training institutes. The Committee would be responsible for accrediting and licensing all hospitals and polyclinics as a condition to participate in any government insurance programs. The Committee would also publish CQD reference materials, catalyze the development of a Training Program on CQD, and periodically issue guidelines on CQD.
2. Use MES as guidelines to shape research into Continuous Quality Development demonstration projects in all Regional Hospitals.
3. The Federal Fund should expand its capabilities in CQD and in the dissemination of cost effective models contracts and manuals of CQD in hospitals and polyclinics.
4. The Ministry of Health should convene a special panel of CQD advisors to serve as judges for a "Minister's National Award for

Excellence in Continuous Quality Development". One for hospitals and one for polyclinics.

Initiative 8: Attract New Capital for Health Sector Infrastructure Improvements Through the use of new "Health Security Bonds"

Strategies to Achieve Initiative:

1. Publish Federal report on the status of age, location and quality of their physical facilities and medical equipment inorder to generate "Capital Improvement Plans" (CIP) forecasts for the next 10 years for each oblast. These CIPs would include recommendations for minimum capital budgets to replace, remodel, or build new hospitals and polyclinics. World Bank consulting assistance should be requested to help complete this strategy.
2. Enact a law, and appropriate regulations, that allows oblast administrations to establish "Health Security Bonding Authority" organizations that have the right to issue "Revenue Bonds" to individuals and institutions who are motivated to strengthen their local health system, persons or organizations purchasing these Bonds would receive (tax reduced) interests from "Bonds" that are guaranteed by (a) the perceived capacity of a "borrowing" party to pay back the Bond and offer competitive interest rates, and (b) the full financial authority of the oblast government. Interest earned on money "invested" in the Bond should be tax exempt as an inducement for funds flow from the market through these bond instruments to local hospital and polyclinic projects.
3. Bonds could only be used for infrastructure improvement projects that are mentioned in the oblasts "Capital Improvement Plan" (CIP), and for which recent a "Certificate of Need" has been issued by the appropriate Regional Medical Planning Authority (see Initiative 9 below).
4. All financial affairs of these Bond Authorities are to be audited by the Ministry of Health and reported annually to the public.

Initiative 9: Revitalize a Reliance on "Population Based" Regional Health Planning as conducting by "Regional Health Planning Authorities" which help assure the better use and deployment of medical infrastructure and technology inorder to:

- **encourage restructured polyclinics that have new General Practices offices;**
- **establish integrated systems of health service delivery and finance within oblasts and rayons; and**
- **reduce unneeded hospital capacity.**

Strategies to Achieve Initiative:

1. Enact a law that requires each oblast to establish a special "Regional Health Planning Authority" that is responsible for developing and publishing to the public an "Annual Health Improvement Plan." This Annual Health Improvement Plan is to define specific actions to improve measurable indicators of health status; i.e. "Health Gain". The Plan is also to define specific criteria that are used to determine whether a major hospital or polyclinic capital improvement project is really needed. The Plan is to be developed through an open public

process that encourages participation by local citizens, physicians, hospital managers, enterprise managers and health insurance managers. These plans are to be the basis of issuing "Certificates of Need" for any major capital improvement project that wants to access the favorable Bond Financing;
2. The Ministry of Health is to fund a special Task Force to define model planning processes, model plans, and model criteria for consideration and possible use by the oblast Regional Health Planning Authorities;
3. The Ministry of Health will publish an annual report to public and to various international health bodies regarding (a) a "National Plan for Health Gain", and (b) the progress being made to achieve prior Plans at the Federal and Oblast levels.

Initiative 10: Establish New Information Systems for Local Health Institutions and Insurance Companies or Territorial Funds, at both the Oblast and Federal levels, inorder to Generate Statistics Needed for Better Reporting on Health Sector Quality, Quantity and Cost Performance.

Strategies to Achieve Initiative:

1. Enact policies needed to establish a standard set of "National Accounts and Reporting Systems" that assures Russia's health sector's funds flows and service use statistics are comparable with (OECD) and the World Health Organization (WHO) standards. These systems will require consistent and standardized financial accounting and statistical record keeping at the individual hospital, polyclinic, pharmacy, physician office and related health care institutions. Special awards and sanctions are to be established to encourage the prompt and accurate preparation and reporting of these statistics by each rayon and oblast;
2. The Ministry of Health will form a special Task Force to develop and oversee the implementation of their new reporting system. The Task Force will seek funding support from international finance organizations to support this process. The Task Force will exist for 24 months and then have its functions assumed by the "National Health Policy Committee" that advises the Ministry of Health on practical goals and strategies for health gain improvement cited previously in Initiative 1 above. The Task Force will have representatives from the Ministry of Health, The Ministry of Finance, The Federal Fund and local hospital managers and insurance companies.
3. The Ministry of Health is to publish an annual report to the public, the Parliament and to international health organizations and the OECD the funds flows, health status statistics and health service utilization statistics.

Summary:

Ten (10) major strategic initiatives are proposed to advance the performance of Russia's health sector for the 21st Century. These initiatives require many strategies and investments during 1996-1997. Bold and creative leadership is needed to refine and implement these proposals by the Russian Parliament and Government. International resources should be sought to help in this refinement and implementation. The two following attachments offer additional discussion of some of the important concepts and principles that help support the need for the proposed initiatives and strategies.

Attachments to

New Accountabilities for Health Gain:
A Concept Paper for Russia
Health Sector Performance Improvement

Attachment 1: **Traditional Problems;**
Traditional Goals;
Non-Traditional Strategies.

Attachment 2: **Theoretical Considerations in Russian Health Sector Reform**

Ατταχημεντ 1

Traditional Problems; Traditional Goals;
Non-traditional Strategies

A. Traditional Goals of the Welfare State:

Russia has a 70 year tradition of a large government responsibility to safeguard and enhance the health and social welfare of Russian citizens. Since the mid-1950's, the Government of Russia has been proud of its goals of socialism wherein the State provides needed health and social welfare services, such as:

* public health and sanitation;
* control of communicable diseases;
* health promotion and preventative health care;
* routine diagnostic, treatment and rehabilitative care for injury and illness;
* wage replacement during illness, injury or maternity leave, and
* a variety of social welfare and support programs, services and facilities.

Paralleling other socialist states, Russia's past health and social welfare policies, investments and systems have embraced the fundamental precept that "...society can restructure its economic institutions along just and morally sound lines so as to insure fairness to all..."* Utopian socialist goals are seen in this 1951 quote from the Socialist International in Germany:

"Socialism seeks to replace capitalism by a system in which the public interest takes precedence over the interest of private profit. The immediate economic aims of socialist policy are full employment, higher production, a rising standard of life, social security, and a fair distribution of incomes and property.

"In order to achieve these ends, production must be planned in the interest of the people as a whole.

*"Such planning is incompatible with the concentration of economic power in the hands of a few. It requires effective democratic control of the economy."***

While these goals for equity of access, cost and quality in health and social welfare services remain laudable, it now seems evident in Russia that new strategies and systems are needed to move closer to their achievement.

New strategies to achieve traditional goals must be developed through a reexamination of new ways to manage three interrelated concepts: (a) the costs to society associated with providing (b) the varying risks of needed health and welfare, and (c) the sharing of responsibility to meet society's economic burden of the welfare state.

The USAID Zdrav*Reform* Consultant Team believes that fundamental realignments of these three variables can yield positive and cost effective progress toward the traditional goals of the welfare state. These strategies will not be easy to design, implement or operate without the full participation and sharing of appropriate responsibilities by all parties. To achieve a new state of equilibrium, a redefinition of new incentives for behavior change among all parties will be needed. Since the 1991 health reform initiatives, the new infrastructure within the Russian State will be needed to house and nurture these new incentives.

B. Shared Responsibilities and Risks:

Contemporary international medical and social science research clearly emphasizes that any society's expenditures for health and social welfare services are a function of:

* ***the number and type of service units consumed by the people;***

* ***the costs of producing and providing the service units by health care professionals;***

* ***the efficiency with which funds needed to pay for the units consumed are accumulated by the state (at either the federal or territorial levels), and***

* ***the efficiency and manner in which funds are distributed by the State (or its agents) to pay for services consumed.***

The USAID Zdrav*Reform* Consultant Team believes its experience in various oblasts of Russia indicates/demonstrates that the responsibilities for appropriate performance within each of these four arenas needs to be refined. Designing and operating new systems and policies will be necessary to assure that the proper incentives for performance exist within the transformed Russian welfare state of the 21st Century. Exhibit 1 and 2 provide insights into the type of changes contemplated by any modern society within the interrelated areas of responsibilities and incentives. These alternatives need to be challenged and studied more carefully during future work by the USAID Zdrav*Reform* Consultant Team in cooperation with officials of Russia.

C. The Concept of Insurance in Russia's New Economy:

Health care or sickness insurance exists in a context of several Forms of Social Insurance:

The economic burden of loss associated with many societal risks can be pooled and shared by groups of people. This pooling and sharing of risk is fundamental to the concept of "insurance." Socialist countries define and manage these risks in a variety of ways, that is, the State "insures" or "pools" the economic costs associated with a variety of health and social welfare services on behalf of the individual citizen and family. The State, at either the federal or territorial levels, needs to accumulate funds derived from the society's economic activities associated with the production and distribution of goods and services. These funds are raised usually by a tax levied as a percent of the wage base, and paid mostly (70-80%) by the employer-enterprises, and a minority (30-20%) paid by the worker. A special portion of a Value Added Tax (VAT) can also be considered as a source of funding the 21st Century Russian Health Sector.

Such cost sharing reflects an ideology of social solidarity that those most able to contribute to the individual and society's

health do so on behalf of themselves and for those less fortunate. Increasingly throughout the world, these funds flow from a single, dedicated sickness insurance tax and/or "premium", rather than being intermingled in the overall government treasury. These funds are managed by the State (either by a single federal or

EXHIBIT 1: A New Balance of Shared Responsibility in the New Social Compact

Modern Risks	*Societal Goals Consistent with the Modern Concept of Safety Net*		*Lead Responsibilities*
Retirement	*Goal 1:*	Assure that citizens retire with basic **dignity** and income	• Basic pension from • State • Supplemental support from family and private insurance
Unemployment	*Goal 2:*	Assure that citizens are insulated from the loss of income due to economic forces of their control	• State to provide for new "Unemployment Insurance Fund" • Employer to share costs
Lost Income from Disability	*Goal 3:*	Assure that citizens do not bear the full risks of lost income due to illness or injury	• Disability wage replacement by State with employers participating in costs
Loss from Workplace Injuries	*Goal 4:*	Assure that citizens do not bear the full risks of costs for medical services due to workplace related injuries or illnesses out of their control	• Disability medical costs borne by insurance fund that is closely coordinated with wage replacement and regular health insurance • Employers share risk based on experience
Health Care	*Goal 5*	Assure that citizens are avoiding financial loss and human suffering resulting from injury or illness outside of the workplace, with full subsidy for financially indigent persons	• National Health Insurance Fund established by State with funding from "premiums" shared by employer and employees, and State subsidy for the indigent
Social Welfare	*Goal 6:*	Assure that citizens are provided social welfare support for services they need to protect their basic productivity and well-being	• Ministry of Health provides from General Tax Based Budget
Environmental Health Hazards	*Goal 7:*	Assure that citizens are protected from the risks of environmental health hazards caused by the broader society and industrial expansion	• State covers risk from general tax based budget and fines to industries in violation of regulated standards • Ministry of Health coordinates intersectoral responses

In all of these areas of Risk Management, the State could exercise control by promulgating regulations and basic standards that protect the fundamental rights of the individuals for optimal well-being. New roles for the private sector must also be explored.

EXHIBIT 2: New Incentives for All Parties to Assure Appropriate Roles in Managing the Risks of Health and Social Welfare

Parties who Share in Health and Social Welfare Risks:	*Positive Motivation:*	*Negative Motivation:*
• Individuals • Families • Employers • Local Government • Country Government • Health Care Providers • Social Service Providers • National Government	• Tax credits or deductions for health and fitness programs - to citizen - to employer • Special grants or funds to encourage achieve standards - of quality - of accessibility - of efficiency • Opportunities to share in surpluses resulting from higher quality and/or lower cost risk avoidance management	• Regulations to: - stop smoking - stop polluting • Fines for unsafe workplace • Fines for poor quality service or not being "accredited" • Fines for incompetent administration of public or private enterprises entrusted with public welfare • High excise taxes on: - alcohol - tobacco

network of territorial public agencies) through a variety of governmentally controlled investment instruments (e.g., government bonds) to maximize interest income. The State then distributes from these pooled funds moneys needed for the provision of services and/or cash benefits guaranteed to the members of society deemed eligible for the benefits. The State through an elected parliament and special agencies of federal or local governments, on behalf of the individual members of the society, defines who is entitled to what level of benefits. In Russia, further work is needed to define a "Basic Minimum Package of Health Service" that could then be actuarially priced and contracted for by a mix of public or private health insurance organizations.

In Russia, as in most socialized systems, the insurance concept generally has not relied much upon "private" persons, organizations, agencies or companies to assist in the management of insurable risks; or the accumulation of funds into the risk pool, nor the management of funds within the risk pool, nor the distribution of funds from the pool to cover the cost of benefits to persons entitled to receive them. Until the reforms of 1991 and 1993, the Russian Government has traditionally chosen to perform all of these insurance management roles through a single government agency, the Ministry of Health. This agency of the State has even owned and operated the system that produces and provides the health and social welfare services (i.e. owns all hospitals, clinics, sanatoriums and employs all physicians and other health manpower). As a result of the landmark 1991 and 1993 legislation, however, Russia now appears ready, as are most other countries, to reconsider alternative answers to a fundamental question of public policy.

...How can the State better meet its traditional socialistic goals for health and social welfare by redefining the ways in which it chooses to manage the basic principles of "insuring or indemnifying" the individual citizen and family from the economic burden of losses associated with the following risks?

Risk 1 ...risk of retirement without a basic level of income to maintain dignity and avoid an unnecessary burden on others in the society.

Risk 2 ...risk of lost income due to unemployment caused by forces in the economy beyond the direct control of the employee.

Risk 3 ...risk of lost income due to injury or illness.

Risk 4 ...risk of medical costs associated with injury or illness in the workplace beyond the direct control of the individual.

Risk 5 ...risk of medical and hospital costs associated with illness not related to occupational safety concerns, i.e. routine medical, surgical and rehabilitation care.

Risk 6 ...risk of costs associated with social welfare services for maternity, child care, elderly care and related needs.

Risk 7 ...risk of illness due to environmental health hazards caused by the broader society and industrial expansion.

Insurance for and management of these risks in society generally require such sufficiently different responses to the following variables that special "insurance risk and risk management funds" are frequently judged necessary. Each risk can require...

(1) different dynamics about factors causing change in the incidence of demand or level of risk;

(2) different burden of economic costs on the society;

(3) different data to be gathered, processed and stored for actuarial monitoring and forecasting;

(4) different accounting and computer data processing hardware and software systems;

(5) different people and segments of society associated with the incidence and management of the risks;

(6) different political sensitivities about the scope and nature of ways to raise funds into the insurance risk pools.

As a result of this complexity of identifying, funding and managing these risks, most countries now find it extremely difficult and inappropriate to place all of these insurance programs in a single risk pool. Separate but coordinated insurance funds are frequently required to assure that dedicated and experienced management focus is directed to the unique challenges of each form of risk.

Throughout the world it is now becoming evident that aggregating all of these risks into a single agency, such as a Ministry of Health, the potential for confusion, dissipated management focus and diluted management systems can result in a dangerous lack of accountability and cost effectiveness. With disparate risks thrown together, it is extremely difficult to maximize the benefits to the society of expensive entitlement programs. Thus, in Russia, it is important to keep separate but closely coordinated, the functions of the Ministry of Health and the network of territorial compulsory insurance funds.

D. The Concept of Incentives

The 1991 and 1993 parliaments recognized that the past Russian approach to insure and manage the risks of diverse health and social welfare needs was suffering, not only from a lack of focused and dedicated risk management systems, but also from

policies and systems that created incentives that were counterproductive to the cost effective achievement of the State's traditional health and social welfare goals. The Zdrav*Reform* Team has found it essential to remind all policy leaders that all parties that contribute to the risk in each of the seven societal risk areas must assume an appropriate share of the motivation to manage the risk. All parties, collectively, ultimately carry the economic burden of wasted societal resources if these risks are not properly managed (i.e. risks are avoided and unnecessary costs of curing the risk are minimized). All parties must, therefore, be sufficiently informed and motivated to play their appropriate role in risk management. All parties must also share in their fair portion of the society's economic collective burden.

After three years of experience with its recently enacted health sector reforms, it has become evident that even further changes and policy refinements are needed if Russia is to assure that its health and social welfare sectors are positive contributors to, and not a drain on, the society's economic and social well being. New incentives are needed in Russia for all parties to become more actively and appropriately motivated to assume their fair share of the society's burden for health and social welfare. Those segments of society that are economically or otherwise disadvantaged and unable to carry as much of their per capita share of the risk need to be supported through the collective efforts and resources of others through mechanisms established and operated within the ultimate guidance of the State. Exhibit 2 provides an illustration of alternative incentives that the State could make available to each party to help assure the more cost effective achievement of traditional societal goals in health and social welfare.

The individual citizen and family must have an incentive to:

* avoid lifestyles that steal scarce economic resources from fellow citizens to pay the substantial societal costs associated with poor or inappropriate fitness, eating, smoking, alcohol or drug abuse habits;

* avoid using service providers that do not meet reasonable standards of quality and cost effectiveness; and

* avoid unnecessary use of expensive medical, surgical and pharmacological technologies that are not proven to be cost effective.

Health Care Providers must have new incentives to:

* strive for high quality of care with fast and cost effective restoration of citizens to their optimal level of health;

* avoid the unnecessary use of expensive medical technologies;

* encourage patients to follow better personal lifestyles and/or safety in the work place.

Both governmental and private sector employers must have new incentives to:

* avoid unsafe work conditions or settings;

* encourage injured or healthy workers to use only the most cost effective health care service providers; and

* avoid environmental pollution practices.

Agencies of the State, at either the territorial or federal levels, must also have new incentives to:

* avoid inefficient practices and policies that misuse scarce public funds or jeopardize the public trust;

* actively seek out innovations in the provision of goods and services that help assure the more cost-effective pursuit of health and social welfare goals.

Strategy to Establish a Refined Oblast and Federal System of Compulsory "Sickness Insurance Funds"

This section describes key refinements to be considered for the recently implemented system of Territorial Mandatory Health Insurance Funds. It has become clear that the ultimate design of the Compulsory Health Insurance' structure, role, responsibilities, and operating behavior will be directly influenced by developments in the broader political and economic context of Russia. Reforms within the health care delivery system are also judged to be essential prerequisites to the success of reforms within the health care financing systems.

A. Review of Compulsory Health Insurance:

The purpose of **Compulsory Health Insurance** in Russia is to assure the ongoing availability of financial resources needed to support comprehensive curative and selected preventive health care requirements of the citizens of Russia. In keeping with the government's traditional commitment to make available reasonable access to quality health care with minimal economic obstacles, this insurance program is designed to pay for a majority of the costs of providing covered services with only modest copayments required at the point of service delivery. (For further discussion on copayments, see sections below). The **Compulsory Health Insurance** is responsible for managing the risks associated with the payment for health services provided for illness and injuries of the general public which might occur either on or off the job. The new **Compulsory Health Insurance** needs to be established to be self sufficient upon contribution fees paid by employees and employers. Levels of subsidization from the general tax-based treasury would be made available to this fund to support the premium costs of economically indigent segments of the population. The current 3.6% of wage base is neither the actual tax burden on the wage base, nor is it a large enough percent to meet the full costs of Russia's health care needs. These needs to be a marriage of budget funds from the social welfare tax and the 3.6% medical insurance tax to achieve a dedicated tax of at least 8.6%.

B. Structure of Compulsory Health Insurance:

Paralleling current discussions regarding ways to strengthen Russia's new social security and pension fund, the new **Compulsory Health Insurance** must accelerate its efforts to operate a federal-territorial system of modern chart of accounts and financial management systems within guidelines provided by legislation and regulation promulgated by the Parliament. Significant authorities for self governance can still be delegated to the territorial insurance funds, but discussion is now needed about how much decentralization is needed for future performance improvement.

C. Governance of Compulsory Health Insurance:

It is anticipated that the policies and plans for ongoing development and management of the new Territorial **Compulsory Health Insurance** would be established by a new "Board of Directors" appointed by the Parliament. This Board of Directors would help insulate the **Compulsory Health Insurance** from complexities of other aspects of the governmental policy development processes, but also assure that ultimate control would rest within the Parliament. Composition of this governance structure will need to be defined during future planning discussions. Preliminary concepts would suggest membership to reflect the unique perspectives of the Ministry of Health, local municipal governments, physicians and hospital leaders, trade unions, employers and the general public at larger. The size of this governing body should be kept to a manageable level, which is anticipated to be approximately 25 members. Terms of appointment to the governing board would be staggered to assure continuity of leadership and explicit expectations of performance and effectiveness by individual appointees. The Board would receive significant discretionary policy development and management prerogatives by delegation from the Parliament. This Board would be, within the constraints of Parliamentary guidelines, relatively free to define future policy in the following areas:

* individuals covered by the insurance plans;
* benefits covered;
* methods of establishing and raising contribution fees and/or premiums;
* levels and methods of paying for health services;
* arrangements for hiring or contracting with individuals and organizations for the provision of management accounting, and computer information
* quality assurance and utilization review standards;
* provider relations;
* eligible member or "policyholder" relations.

D. Intersectoral Coordination:

Ministry of Health:

The refined **Compulsory Health Insurance** would be expected to develop its plans and budgets at the Oblast and Federal levels with structured and frequent coordination with the Ministry of Health. The chief executive officer of the **Compulsory Health Insurance** would likely assume his/her position at the discretion of the Board of Governors, but only after this Board sought consultation and input from the Minister of Health. Monthly meetings and reporting relationships of statistical information to the Ministry of Health would be anticipated. Specific elements of oversight and coordination would need to be explored further during the next two years.

Other Social Welfare Risk Pools:

The Compulsory Health Insurance Board and senior management would be expected to interact in a number of ways with other insurance and regulatory bodies such as pension and retirement, wage replacement for work related injuries or disability, unemployment insurance and environmental health protection agencies.

One of the most frequent and structured forms of intersectoral coordination should occur between the short term disability insurance fund and the Compulsory Health Insurance. To assure maximum managerial focus upon the unique risk management needs of both the short term disability challenge and the routine health care challenge, it has been proposed that separate insurance funds function. The ongoing monitoring and control of disability reviews and eligibility for medical and/or wage replacement benefits drawn from the short term disability insurance pool, however, would be by physicians employed within the Compulsory Health Insurance quality assurance and utilization review monitoring group. As these funds established their data base, management expertise, policy and quality confidence, it is possible that the management and governance controls and systems for the funds could be merged later in the 21st Century. Attempting to operate two separate funds under a single governance and management structure initially is expected to create too many opportunities for diversion and diffusion of management focus. The risks are sufficiently different to warrant dedicated staff and financial management systems to assure the most cost effective design and initial operations of these risk pools. Further exploration of the scope and nature of these coordinated relationships would need to occur during the next three years.

E. Management Systems and Capacity:

The territorial **Compulsory Health Insurance Funds** need dedicated management policies and procedures, as well as refined accounting and financial systems and comprehensive statistical data processing systems and staff. The Board of Governors for each fund should have at its discretion the ability to either hire staff necessary to design, develop and operate these needed protocols and systems and/or contract with outside organizations for all or significant portions of the needed management infrastructure. Governmental agencies throughout the world are finding it cost effective and timely to contract with outside organizations within the private sector to perform such services within explicit performance guidelines and oversight controls by the governmental agency. Further dimensions on how such contracting might evolve in the **Compulsory Health Insurance** should be explored during the next two years.

F. Covered Population:

The initial design for the **Compulsory Health Insurance** has been based on the presumption that all citizens of Russia would be eligible to participate as a "subscriber" to the new insurance funds. Exceptions to this may be defined by Parliament to include individuals in other existing delivery systems such as railroad workers, police, members of the military and the dependents of these respective groups. Further definition of the scope and nature of these covered and uncovered groups must occur during the next three years.

G. Basic Service Benefits:

Extensive additional study and discussion during 1996-97 is still necessary to clearly identify a basic, minimum set of benefits covered and the level of coverage to be paid from the funds. At the moment, it is anticipated that comprehensive inpatient and outpatient diagnostic, curative and rehabilitative services are to be provided to the subscribers. In the future, certain levels of coverage would probably be restricted for services in the following areas:

* chronic alcoholism and drug abuse;
* certain organ transplants;
* certain chronic care associated with certain mining related lung or tuberculosis problems;
* certain aspects of psychiatric or mental health;
* certain aspects of dental care;
* certain aspects of over the counter and prescription pharmaceuticals.

The definition of covered services and the degree of coverage would need to be defined annually in a joint memorandum between the Compulsory Health Insurance and the Ministry of Health.

H. Paying Providers:

For the next five years, it is anticipated that ownership and operating responsibilities for the health service delivery system of

Russia will remain largely within the public sector whose quality is monitored and supported by the Ministry of Health. Agreements on the scope and nature of payments from the Compulsory Health Insurance to the providers operating must be negotiated annually. During the 21st Century as private sector physician, dentist and hospital operations become more feasible, payment arrangements for the private sector providers would also need to be studied and established. Wherever possible, payment from the Compulsory Health Insurance to either governmental entities such as municipal or oblast governments and/or provider organizations or individual providers must be done in a manner that provides appropriate levels of incentives for quality of care and cost effective use of expensive health resources. The philosophy and protocols for provider payments must be evaluated during the next three years.

The initial concept to be explored, however, is suggested to be a payment of capitation amounts to rayon and/or municipalities for all preventive, primary and outpatient services on a per capita basis where incentives for cost effectiveness would be focused at that local governmental level. Payments for inpatient secondary and tertiary services would probably be designed to occur on a global budget, or Diagnostic Related Group (DRG) type basis to the affected providers. This would enable hospitals and integrated hospital systems to have economic incentives to maximize cost effective operating policies and procedures. Such a balance of capitation and DRG type payments would also be intended to constrain the monthly and annual claims processing burden to a more manageable level. Movement to either fee-for-service or DRG payments for outpatient areas is not believed advisable at this time because of the significant lack of experience and data processing capabilities in Russia for the several million claims per month that would need to be handled by such policies. This approach also would attempt to take maximum advantage of the existing infrastructure currently used to pay for the salaries of physicians and health workers throughout the country without having to institute completely new systems for such costs.

I. Quality Assurance:

The Compulsory Health Insurance would need to work in cooperation with the Ministry of Health to establish and monitor standards of patient care quality and subscriber satisfaction. Structured utilization review systems would need to be developed and appropriate regulatory and economic sanctions established to assure compliance with these standards. Monitoring protocols would need to be established during the initial design of the new Compulsory Health Insurance. Quality assurance and utilization review standards from Europe and the United States would be used as initial starting points for this complex design and development challenge. There are substantial opportunities for reducing unnecessary hospital and patient care activities by applying new standards for quality and utilization management.

J. Health Promotion For Long Term Health Security:

While it is anticipated that the principal leadership for sanitation, routine public health and communicable disease control would remain within the Ministry of Health, it seems prudent for Local Territorial Compulsory Health Insurance Funds to allocate a certain portion of their funds and attention to the encouragement of proper lifestyles and health behavior by its subscribers. Annual and five-year health promotion plans should therefore be developed cooperatively between the Compulsory Health Insurance Funds and the Ministry of Health to encourage maximum access to preventive health services and health promotion and education programs. Priority attention would need to be focused on such areas as hypertension, avoiding cardiovascular risk, stop smoking campaigns, and certain prenatal health programming.

Conclusion:

The design and development of a refined Compulsory Health Insurance Fund continues to be a complicated challenge. Extensive debate and study of alternative design considerations must occur within the next year. Additional Compulsory Health Insurance policy design principals to be considered and explored during this work of future are outlined in the following points:

1. New legislative and regulatory mechanisms to enable expanded funding for health care that is separated from the existing tax based general budget will need to be addressed in a special "White Paper" to the Parliament:

    * Separate funding for selected curative health care will need to assure proper allocations and management by establishing a separate payroll related tax or premium as it's primary revenue source.

    * Policies will need to be promulgated that assure efficiencies achieved within the system should accrue to the benefit of those organizations responsible.

    * Over time, sufficient cash reserves should be established to maintain the self sustaining strength of the Compulsory Health Insurance Funds and to avoid unexpected drains on their national treasury.

    * A broadly based coalition of health care, employer, consumer, local and national government leaders should be formed to facilitate reform. Such a coalition should begin meetings at county levels to discuss proposed reforms and gain local insights.

2. Oblast and rayon authorities should receive moneys from the Compulsory Health Insurance to encourage cost efficient allocations of operating funds.

    * Future should evaluate how providers are paid on a per capita basis while still taking into consideration the allocation of moneys in terms of (1) age/sex breakdowns, (2) level of care provided (tertiary, secondary), (3) relative cost differentials by geography.

3. Existing regional and local health planning bodies should be reassessed to determine appropriateness of the scope related to decision making role.
    * Oblast health care committees should evaluate at what level should decisions regarding primary care, specialty care, diagnostic care, normal acute inpatient care, and specialty inpatient care be made.

    * Possible redrawing of regional health planning districts in oblasts should be considered.

4. An assessment of inpatient facility needs, with consideration of consolidating existing facilities to better concentrate resources on fewer, better equipped and managed hospitals, should be performed.

    * Duplication of services would be reduced.

    * Savings achieved would be used to upgrade diagnostic and treatment facilities of remaining hospitals.

    * Occupancy rates would increase, causing a more productive and effective use of scarce equipment and manpower resources.

5. A reduction in the level of subsidy from the Compulsory Health Insurance for drug and dental benefits might be considered to help facilitate the redevelopment of funds for more needed reforms in the medical sector.

    * Co-payment levels for drug benefits could be increased with annual out-of-pocket ceilings.

    * Out-of-pocket ceilings could differ between various groups.

    * New supplemental insurance plans could be made available in the private insurance sector to cover out-of-pocket drug costs.

    * Institution of expanded copayment schedules for dental care.

6. Health care delivery systems which are cost centers within oblast and rayon budgets (e.g. integrated system of clinics and hospitals) should be paid in a manner to promote more cost effectiveness.

   * Hospitals shall be reimbursed on either a global or DRG type basis for inpatient care, and a form of capitation for outpatient and related costs.

   * The bases for such payments would probably need to be based upon lessons from the current pilot prototype projects.

   * Savings achieved under the DRG and per capita payments should be available at the local level to benefit the responsible organization.

   * Operating savings are expected to be achieved by special programs to restructure the ways in which care is provided by avoiding unneeded hospital stays, and attrition and other forms of staff reduction. Special analyses of the consequences of staff or physician reduction must occur in the future.

7. National standards should be established by the Ministry of Health for future capital construction and equipment purchase. All future capital budgets should be restrained by these standards.

   * A national panel of health care delivery administrators, council representatives, finance experts, and industry and union spokespersons should convene to establish physician and nurse staffing ratios, equipment requirements based on geographic economic, and equity needs within each region.

   * A national survey of capital and equipment needs must be completed upon which to base forecasting of future.

   * Equipment and construction needs should be defined on a long range, phased-in plan.

   * National capital planning goals and objectives must be balanced against local concerns and realities. National planning bodies would coordinate and negotiate capital needs planning with local planning bodies.

   * In the long term, provider payment mechanisms from the Compulsory Health Insurance to regional governments and national facilities must reflect the true costs of capital and depreciation of equipment.

8. Health financing reforms within the proposed Compulsory Health Insurance should also be designed in future to encourage physicians to follow cost effective care protocols. New incentives will be needed that enable physicians to

receive greater access to better technology and compensation by avoiding practice patterns that consume inappropriate levels of health care resources.

* Studies should be encouraged that evaluate how physicians might form separate corporations and contract with integrated hospitals, polyclinics and institutes for purposes of providing selected medical services.

* During the 21st Century, new types of physician professional corporations could be encouraged by a mix of regulation and economic incentives. This new flexibility could be defined in contracts between the integrated hospital or national institutes.

* As has recently been proposed in England, primary care physicians should be eligible for risk incentive pools based on integrated hospital specialist and drug use profiles. An initial program should be started with expected system-wide implementation after 1999.

* Further physician capitation projects should be established for research and development purposes.

9. The refined Compulsory Health Insurance should be encouraged to cooperate with the Ministry of Health to develop new health care management training programs for physicians and lay personnel. These programs should address health care delivery and administrative (accounting, data systems, provider relations) issues. Faculty could be brought in from the US and Europe and coordinated with other Russian/western business school ventures. Curriculum could include, e.g.:

* Health care ethics
* Utilization review methodologies
* Incentive reimbursement methods
* Use of computers in hospital and outpatient environments
* Financial planning/management
* Human resource management
* Patient centered care
* Quality and risk management

10. The **Compulsory Health Insurance** would need to establish comprehensive new policies and systems for Utilization Review:

    * LOS (Length of stay) and outpatient surgery standards should be introduced on a nationwide basis using lessons learned from both foreign and local experience.

    * Utilization Review (UR) personnel should be designated in all hospitals and triaging programs established.

    * The Ministry of Health could seek Russian and/or international funding support to help create a UR training institute.

11. Future studies of alternate physician payment methodologies should also include new incentives such as copayments to avoid unnecessary utilization by patients of expensive or unneeded services. Institutionalization of tax benefits for these copayments within the new income tax structure could, over time, reduce the prevalence of existing physician gratuities. Future studies should evaluate different potential copayment levels and alternative mechanisms for collection of copayments by physicians and hospitals.

B. New Physician Compensation

Levels and Forms of Salary:

Countries throughout the world have found it extremely difficult to transform their health delivery systems without involving the creativity and leadership of their medical community. Physicians in Russia appear reluctant to continue the health policies and procedures of the past. Behavior change to embrace new and potentially controversial policy reforms will not be easy unless physicians are more positive about their role in the Russian society. While prestige and status are of course of interest, the pressing issue will be compensation levels for physicians of all specialties. Health system reform must involve dramatic reforms in the level and methods of compensating physicians in both outpatient clinics and inpatient hospital settings. These two analyses will need to examine the scope and nature of increases to physician base compensation levels required to elevate their enthusiasm for new policy changes. The same studies must examine ways to provide positive incentives for greater involvement in utilization review, quality assurance and avoidance of unnecessary resource consumption. A wide variety of positive and negative incentives will need to be explored. Negative sanctions such as fines or constraints on privileges for improper quality or utilization patterns would not be productive. Most countries discover, however, that positive motivations prove more fruitful. Economic incentives derived from reasonable participation in surpluses that can occur through use of DRG-type compensation arrangementsfor inpatient care should be studied. While hospital inpatient care could be reimbursed on a DRG-type basis, it is quite likely that physicians would continue to remain on a salary basis. These salaries, however, could be established with a relatively fixed base per specialty, with the opportunity to earn more based on productivity and exceeding standards of high-quality service and patient satisfaction. Multi-specialty group practices in the United States have found a variety of compensation formulae to utilize in this regard.

Bring Gratuities out of Shadows into Sunlight:

The persistent role of "gratuities" must be explicitly evaluated during the transformation process. The right of an individual to provide economic rewards for exemplary service could be understandable. In Russia, however, these gratuities have evolved to a position of expected "fee for service" and, in fact, appear in some instances to represent bribes to subvert the routine processes of the health delivery system. Such difficulties also are not equally borne by the society. Higher-income individuals find it easier to provide more attractive gratuities and therefore can gain a disproportionate access to needed and scarce health resources. This situation must be questioned in light of the espoused Socialistic goals of the Russian state.

These two analyses must explore ways to either make gratuities illegal and/or to at least "institutionalize them through the tax system." Receipts would be an obligatory responsibility of physicians receiving gratuities. Individual patients would be motivated to request such receipts through a tax credit or deduction

within the new Russian income tax system. Such receipts would enable audit trails for periodic examination of the appropriateness of physician income reporting of gratuity revenues. The Ministry of Health is encouraged to work openly and closely with the evolving medical societies and insurance companies to explore positive ways to resolve the difficulties revolving around the gratuity issue.

C. Cautious Private Practice Flexibility

The government is currently encouraging the establishment of "private practice opportunities" for dentists. While some physicians do see patients outside of their public employment locations, this provision of "private practice health care" is more prevalent in the dental than in the medical arenas. The recent debates over physician unions and reestablishment of professional medical societies is now expected to stimulate further exploration of policy changes to encourage greater private practice by physicians as well as dentists. These experiments, however, must be explored cautiously and in an evolutionary manner.

Countries in Western Europe, and particularly the United States, are experiencing a growth in both the number and size of multi-specialty group practices. These group practices operate within the private sector and use private capital to build and equip outpatient diagnostic and treatment facilities. Privatization of this dimension of health delivery has the attraction of providing new capital to flow into the health care system. However, the rapid implementation of private practice opportunities in Russia could create some difficulties during the early 21st Century. A rapid exodus of high-quality physicians to private practice could jeopardize the caliber of health services available in the public system. Efforts to guard against unnatural barriers between socio-economic classes are to be avoided in all systems, but particularly in a system with the Socialist traditions of Russia.

Investigations should explore the feasibility of demonstration projects in selected cities during the early 21st Century. The purpose of these demonstration projects would be to encourage the development and evaluation of alternative forms of physician groups and organizations. These groups could enter into contractual support relationships with public hospitals and poly-clinics such that public-sector controls over quality and accessibility could be maintained. These contracts for services with physician groups could also be structured to provide economic incentives for proper productivity and levels of patient satisfaction. Such flexibility within controlled experiments should prove to be of optimal advantage for all parties during the transformation process.

Conclusions:

Physician effectiveness in Russia must be enhanced through experimentation with a wide range of organizational and economic

incentive mechanisms. While an oversupply of physicians is expected to become evident in the 21st Century, it is essential that high-quality physicians be adequately rewarded for their leadership role in designing and implementing more cost-effective operating systems throughout the Russian health and social welfare sector. Innovations in the use of utilization review, quality of care standards, balanced use of skills within all allied health professions, cautious expansion in the use of ambulatory surgical procedures and the appropriate use of modern medical technologies for non-invasive diagnostic and treatment purposes can all occur through change in physician status and compensation. Future studies must focus priority time and creativity on cost-effective strategies to continue to embrace ways to increase physician effectiveness while dramatic changes occur in the health and social welfare systems.

Strategy for Regional Health Planning to Modernize Service Delivery Infrastructure

The assessments of the past two years have indicated a number of areas for reform in the delivery of health care services. This section provides an introduction to selected strategies that are to be further explored in future work. Principal areas of consideration are:

* hospital use and bed capacity reductions.

* opportunities for hospital cost reductions under new payment methods.

* central versus regional concentrations of selected medical technology.

* pharmaceutical distribution changes.

Methodology to Determine Centralization/Regionalization Feasibility

The following are services that should be studied during the future to identifies for possible candidates for either centralization or regionalization. Some of them are already centralized or regionalized in Russia. They all contain at least one of the critical components (i.e. high cost of medical equipment to perform service, rapid technological change, high level of professional training required to perform well, potential economies of scale, can be scheduled in advance, patient can generally endure travel). In order to initially assess the feasibility, the current volume of procedures must be known for each of the following type services.

A. Transplant Surgery
B. Non-Emergency Surgeries
C. Neonatal Care
D. Open Heart Surgery
E. Shock/Trauma Units
F. Burn Units
G. Sophisticated Radiological Procedures (MRI, CT Scan, etc.)
H. Acute or Long-Term Psychiatric Care/Substance Abuse Treatment
I. Thoracic Surgery
J. Oncological Treatment
K. Pediatric Surgery
L. Ophthalmological Surgery
M. Neurosurgery
N. Immunological Treatment

Strategy for Health Manpower Development

This section seeks to outline a strategy for comprehensive knowledge, skills and attitude development among all clinical and administrative disciplines. Investments of creativity and capital are believed to be needed in at least the following areas:

* medical education reform;
* nursing professional grants;
* enhanced medical technology specialists roles;
* expanded skills and systems for management.

Future discussions should attempt to challenge and refine the following possible strategies:

A. Medical Education Reforms

There is an acknowledged need to examine new arrangements for the training of medical students and the need to reduce the number of medical school graduates coming into the marketplace. This section emphasizes a simultaneous need to develop strategies for ongoing continuing medical education to enhance clinical skill development in a philosophy of lifelong learning. The recent discussions about enhancing the role,

responsibilities and activities of professional medical societies is expected to help provide a necessary prerequisite for success in the development and operation of high quality continuing medical education throughout Russia. The Ministry of Health, as well as the new Compulsory Insurance Funds, should be encouraged to collaborate in the support of medical society's and colleges to devote their time and talent to the (1) establishment of special "institutes of continuing medical education" within all specialties of medicine and surgery; (2) training more generalists than specialists and (3) retraining specialists to be modern "Family Medicine General Practitioners". International collaboration with specialty society counterparts from throughout Europe and the United States are to be encouraged. Close collaboration in the planning and execution of these education programs should also be sought with the World Health Organization.

As other sectors of the Russian economy seek out innovative east-west philanthropic supported training and education programs within new joint venture university programs, so also should the existing university medical schools. Special international affiliation agreements could be forged with respected university medical schools within Europe and the United States. Faculty exchange programs, special clinical fellowships and rotating short-term

residency opportunities for existing practitioners already in practice should be encouraged. Solicitation of major international pharmaceutical companies to help underwrite such initiatives could also be an important element of this strategy.

B. Nursing Professional Growth

Health policy leaders throughout Russia have acknowledged the need to significantly expand and enhance the professional practice of nursing. The number of nursing graduates must be increased. An expansion of nursing schools and both academic and practical training opportunities has often been cited as a necessary prerequisite to the successful expansion of the number of trained nurses working throughout the Russian health delivery system. As with the above cited strategy for expanded continuing medical education of physicians, the nursing profession should also seek international collaborative arrangements to enhance the initial training of nurses, as well as their ongoing knowledge and skill development. The philosophy of "life long learning" should be encouraged for the nursing and other allied professions throughout Russia. Nursing leaders within the Ministry of Health, as well as local hospital and poly clinics are expected to be quite supportive of broad based and aggressive attention to these details. Special attention for a "National Commission on the Practice of Nursing" needs to be explored further during the future. Nursing leaders should be actively encouraged to participate in the Reforms. The delicate issue of a potential oversupply of physicians and an undersupply of nurses must be addressed in these reform discussions. The job responsibilities of young physicians, vis-à-vis traditional nursing service roles, cannot be ignored as long-term investments are made into nursing training and continuing education programs.

Recent research and program development on nursing practices in Europe and the United States could be of immense practical value to the Russian challenges. An international symposium on the professional practice of nursing could be convened with underwriting support provided by nursing associations from Europe and the United States.

C. Enhanced Medical Technology Specialists Roles

Allied health professionals serving medical advances in radiology, laboratory medicine, inhalation therapy, pharmacy, and a wide variety of other specialty areas will require substantial expansion and enhancements throughout the 21st Century. Existing interests to expand the quality of training and employment opportunities for all health workers must be a fundamental dimension in the health sector reform movement. Compensation levels and status enhancement strategies must be openly debated and supported in. Ten year plans should be developed during phased implementation throughout the 21st Century. International collaboration and support should also be solicited for these various professional groups. International manufacturers of medical technology instrumentation and equipment should be contacted for their participation in both

the design and potential subsidization of these professional development program opportunities.

D. Expanded Skills and Systems for Management

There is a wide range of knowledge and skill challenges that will face physician and business managers of the new Russian health delivery and health financing sectors of the 21st Century. Immediate training and system development in all aspects of management and medical economics must be a high priority for any successful implementation of broad based health sector reforms. The Ministry of Health should be encouraged to immediately explore the development of international affiliations between one of its major university schools of public health and one or more graduate and advanced management training institutions in Europe and the United States. Faculty exchange programs, the development of educational and training materials, development of educational methods and training tools should all be encompassed by this broad based reform in the managerial development at all levels of Russia's health delivery and health financing infrastructure.

While, ultimately, graduate degree training for managers that specialize in hospital and health care management is desirable, a number of short-term strategies could be pursued immediately, such as:

* Short-term (three month) administrative residencies could be established in Europe and the United States. The Association of University Programs in Health Care Administration of the United States is already involved in assistance to arrange for such training opportunities. The counterpart organization for Europe, located in Belgium, should also be considered an ally in the exploration of these needed management development programs.

* Development of faculty exchange programs.

* Arrangement of international affiliations between hospitals in Europe and the United States with major hospitals of Russia. These affiliation agreements would call for short-term staff exchange programs, short-term touring opportunities, and ongoing telecommunication support relationships.

* Short-term consulting engagements which attract specialists in targeted areas from United States and Europe should also be studied during the future work of USAID consulting teams.

Conclusions

The USAID consultant team recognizes that broad health sector reform will require reform and development in the attitudes and behavior of health professionals in all clinical and administrative areas. Infrastructure change cannot occur without intelligent change within the human resource component. Change and enhancement of knowledge, skills and attitudes within the health professions of Russia cannot happen by chance, but can only occur through conscientious planning and aggressive program development. The Health Reform Secretariat is encouraged to add to it's agenda the development of long-term health manpower planning and development strategies.

Strategy for Health Promotion and Prevention: A Need for New Methods and Incentives for Personal and Societal Behavior Change

This section calls attention to the need to examine new investments and innovative programming in a wide range of health promotion and preventive health measures. No significant improvement in health status outcomes for the people of Russia can occur until they are prepared to take greater personal responsibility for their lifestyles and health status improvement. While the state has and must continue to take an even greater role in the encouragement and development of these lifestyle and behavior changes, a number of new incentives and systems must be developed that provide active incentives for the individuals and families to become more proactive in their own health. The utopian socialist goals of State responsibility for the protection of basic rights of the individual must also be balanced with a reasonable expectation of responsibility from these individuals to avoid health risks that endanger the society's and their own personal economic and physical well being.

Rising mortality and morbidity rates in the areas of cardiovascular disease and cirrhosis of the liver make it impossible to ignore the tremendous challenges facing the Russian health and social welfare system from abusive eating, smoking and drinking behaviors. Regulatory, economic and tax incentives should be explored to help attack these problems. While existing excise taxes on tobacco and alcohol generate in excess of 30 billion Rubles in 1994, these excise tax rates could be expanded to help further fund anti-smoking and alcohol abuse campaigns. These public education and preventive measures must be bold in their scope and message. Modern and aggressive advertising campaigns must be developed and launched in a multi-media fashion throughout the early 21st Century. Initiatives being contemplated by the health promotion leaders within the Ministry of Health are to be applauded and aggressively encouraged. The return on invested capital in these forms of public health awareness and health status improvement have been shown in other countries to be significantly higher than similar levels of investment into expensive modern medical technology and equipment.

The national campaign currently being implemented from within the Ministry of Health has a number of positive features which should be encouraged and expanded:

- The concept of a public/private partnership to address these issues at all levels of the society is extremely important.

- Active investment and leadership from local municipalities should be further expanded.

- Grassroots volunteerism from women, children and workers should also be encouraged.

- Active examples for the public must begin from within the health profession itself. Stop smoking programming should

be particularly developed and focused on physicians and nurses during 1997-98. The hypocrisy of large proportions of the health professions actively providing negative role models in health behavior needs to be candidly discussed and addressed. Publicly familiar and respected leaders from business, sports, the arts and other walks of life should actively be enlisted in the design and execution of this new program. Broad based multi-media communication strategies should be designed from the experiences within Europe and the United States over the past five years.

The significance of this problem is such that the government must also deal with the politically sensitive area of legislative and regulatory reforms calling for prohibition of improper behavior such as smoking in certain public and public health areas. Existing international affiliations with the World Health Organization and other stop smoking and drug abuse campaigns within Europe and the United States are positive and should be accelerated for the 21st Century. International conferences scheduled in Russia can help attract broad based public attention and interest in these subjects.

As tax reform becomes better understood throughout Russia, income tax incentives should also be explored for individuals which who to invest their time and money for health behavior modification programs and various preventive health measures. Tax deductions for involvement in stop smoking, weight loss and drug abuse programming should be considered by the leadership of the health promotion programs within the Ministry of Health.

The long range strategic and financial plans for the proposed new National Health Insurance Fund should also establish dedicated funds and cooperative programming with the Ministry of Health to help assure that future demands on the health insurance fund are not unnecessarily consumed by service demands resulting from improper lifestyles.

New Capital Financing

The design, development and initial implementation of the several health delivery and health financing reforms described in this "Concept Paper" will require substantial capital resources not readily available within the existing funding arrangements of Russia. Capital will need to be secured through a combination of redeploying scarce governmental funds from within Russia, as well as pursuing added funding from various international financing organizations. It is conceivable that even within the existing economic dilemmas of Russia, additional international debt and grant support may be necessary to catalyze the needed actions and reforms outlined for the Health and Social Welfare sector.

The opportunity to secure additional funds from within the constraints of the existing and foreseeable future economic context of Russia are not bright. While additional funds are possible for health promotion and various health training activities from added excise taxes upon alcohol and tobacco, these funds are not expected to represent substantial new sources to adequately fuel the broader requirements of Compulsory Health Insurance and the upgrading and repair of existing hospital and polyclinic service delivery infrastructure. Immediate inquires with a variety of international funding agencies should be strengthened during 1996-1999 relations. The World Bank's current involvement in technology transfer and other similar funding sources should also be explored for such important initiatives as those identified below:

- Design and establishment of new accounting and financial management systems for actuarial forecasting of risk within the new health insurance fund.

- Computer systems to support the quality assurance and utilization review protocols.

- Extensive computer systems needed for hospital and clinic reliance on financial management and billing protocols associated with new capitation and DRG type reimbursement arrangements.

- Computer systems to accommodate new management policies and procedures for internal human resource management of the new Compulsory Health Insurance.

- Capital investments for needed medical technology into the health delivery infrastructure operated by local territorial health committees and municipalities and the Ministry of Health.

- Funding for management training in all aspects of medical economics, modern computer science, quality assurance and routine health and hospital management protocols.

- New systems to assure maximum intersectoral coordination between the risk management functions of pension, short-term disability, routine health care and unemployment insurance risk pools.

Contacts with representatives of a variety of governmental bodies within Russia and international funding authorities should be identified and accomplished during the next 18 months. The final proposed "white paper" or "Conceptia" for parliament should address the expected feasibility of such capital support resources.

Attachment 2

Theoretical Considerations in Russian Health Policy Reform:

Basic Concepts to Stimulate Discussion Among Policy Makers of Russia

Table of Contents:

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Theoretical Considerations in Russian Health Policy Reform:

Basic Concepts to Stimulate Discussion Among Policy Makers

Introduction:

There are numerous philosophical and economic principles many developed and developing countries have found should guide the ultimate selection of health financing reform strategies and could be of value in Russia's current exploration of strategic policy refinements in the new "Conceptia". These principles take into account the rather special nature of the production, distribution and consumption of health services by comparison with those of other goods and services essential for a productive society. Many of these special characteristics are not unique by comparison with the production, distribution, and consumption of other social services, e.g., education, and social security services. Thus the philosophy and principles relevant to illuminating the appropriate path to strengthen and refine the financing relationships of the Russian health sector may be of use to other sectors facing major political and economic transformation as well.

As a theoretical background for exploring potential refinements in the health services sector of Russia as it prepares for the 21st Century, review of background on health economic issues may be helpful. The key issues to be considered in developing a new "Conceptia" for Russian Health Sector Performance Improvement are:

- Public versus Private Goods and Services.
- Consumption and Production Externalities.
- Health Care as a Basic Human Need and a Right rather than a Privilege.
- Health Services as an Investment in Human Capital.
- Consumer Ignorance, Price as an Indicator of Quality, the Relative Price Inelasticity of Demand for Curative Medical Services, and Supply Creates Demand.
- Rising Consumers Expectations, and the Implications of Advances in Medical Technology.
- Curative Medical Services as Luxury or Superior Goods, and the Relative Inelasticity of the Supply of Curative Medical Services.
- Interconnections and Interactions Between the Private and Public Medical Sectors.
- Third Party Reimbursement.
- Health Maintenance Organizations and Preferred Providers Organizations in Connection with Fee For Service Private and Public Health Services Delivery Systems.

Each of these items is discussed in general terms below. As usual, there are no panaceas. Solutions for health sector reform will need a new balance of federal and territorial as well as public and private sector initiatives as Russia prepares for 21st Century Health Care. Experimentation will be needed. Cautious implementation is warranted.

1. Public versus Private Goods and Services.

Economists have long known that there are certain goods and services that if left solely to private market forces could be underproduced in quantity relative to the quantum of production that optimally meets the needs of society. Such goods are generally labeled "Public Goods and Services", recognizing the necessity of the public sector to help ensure the adequate provision of such goods and services.

What is the intrinsic nature of ***public goods and services?*** Why might they be produced in below optimal quantities if left strictly to the private sector or to a blind reliance on "the market"? Which of the many goods and services qualify as "public" in nature and what is the appropriate role of Government as compared to the private sector in insuring their production in socially optimal quantities?

Public goods and services are generally recognized as commodities that once they are produced are indivisible and hence cannot be sold item by item or piece by piece to individual consumers. The classic example is a "light house." Once constructed and its beam is illuminated, all ship captains receive the benefit of the warning that the lighthouse provides. It is impossible to divide up the beams of light and to sell them to each individual ship captain who consumes the service and charge them a fee reflecting the marginal benefit received.

Since such services are indivisible, private sector firms rarely are willing to produce and distribute these services, since they cannot sell them unit by unit in order to recover their costs and earn even a modest profit. Examples of health commodities that qualify as public goods, would be fluoridated water supplies, sanitation and public health inspection, and mosquito spraying. Indeed the spectrum of what doctors call "Public Health" is usually considered unattractive to or inappropriate for a total reliance upon the private sector (although the private sector may help produce certain goods or services that could be used in such public
services, e.g. computer systems, vaccines educational materials.)

Since the private sector would likely not go at risk to produce such public
goods and services at all, or would produce, and distribute them in insufficient quantities, it is usually necessary that Government, at either the federal, territorial or both levels, to play an active role in their production and distribution. In playing a positive role,

Government has the following principal options to encourage at least a partial role for the private sector:

- Decree that by law certain private sector entities (e.g. private pharmacies or doctors) must produce and distribute these commodities, subject to penalties if there is failure in compliance.

- Subsidize certain private sector agencies to produce and distribute the commodities in optimal quantum.

- Undertake the responsibility for directly producing and distributing the commodities in question.

The first option is coercive and imposes real costs on the private sector entities coerced into supplying the commodities in question. These costs necessarily must be recovered by marking-up the costs of other commodities that private sector entities sell in order to at least recover their costs and possibly make profit.

In the first option, Government must set-up administrative machinery and procedures and employ staff to enforce the law and its regulations. Cases of dispute must be arbitrated through the nation's legal system. Staff also must be employed to monitor the quality of the services that might be provided via contract with the private sector.

The second option involving subsidization of selected private agencies, requires the establishment of ***competitive contracting procedures***, oversight and administration of contracts and staff to monitor the quality of the services provided. Also, Government must collect the tax revenues needed to fund the contracts awarded to the private sector entities selected to provide the service. Revenues needed must be sufficient to cover the costs of administration of contracts and the monitoring of quality, the private sector costs of production and distribution, and profits sufficient to attract private sector contractors. If profit margins are not allowed, and such contracts are below "opportunity costs", private firms will generally choose to deploy resources to the production and distribution of other commodities, and choose not to bid or accept government contracts for supplying the commodities in question.

The third option requires the collection of sufficient taxes to employ qualified staff to produce and distribute the services and/or commodities in question directly by the Government, with few if any roles for the private sector, except for contracting for selected computer claims processing, training or the provision of certain medical supplies and pharmaceuticals. Quality monitoring and control must be built-in to the public system. In some instances, tax revenues required may be less in this case in contrast to the private subsidy options, since Government would try to supply the commodities at cost with no profit.

The third option involving direct government provision is the option most Governments in the world have chosen in the case of the production and distribution of public goods, because they believe it is cheaper and quality of output is at least as high as most alternatives.

However, note that most Governments tend to under-fund the production and distribution of public health services. The results of expenditures in this area are not very visible and tangible, thus politicians and administrators tend to underestimate the social benefit of such commodities in averting death and illness. Such short-sightedness has a high social cost in that, in the future, greater costs are incurred as illness that could have been, but was not prevented, become more complex to treat. As a result, expensive curative medical treatment and rehabilitation services, eventually are required, and production is lost in the case in which individuals die prematurely. In some cases, charity or voluntary agencies fill in a fraction of the gap between what public health services are actually produced and what society really needs.

2. Consumption and Production Externalities.

The production and consumption of certain commodities confer social costs or benefits that exceed private costs or benefits. These social costs or benefits are ***indirect*** in the sense that they are incurred or received by individuals other than those directly involved in their production or consumption.

An example of a case in which social costs exceed private costs would be a case in which an industrial production process pollutes the air or water supplies of a community, thus imposing indirect costs in the form of higher rates of illness in the population, dirty clothes, houses and autos, etc.

In such a case, social costs exceed the private costs of production. Private firms are not bearing the full costs of production (including the direct costs of production and the indirect cost of pollution), hence costs are understated in the selling price of the product. Since the selling price of the product is understated by virtue of the omission of part of the social costs of production, the quantity of the product demanded is greater and hence production is greater than might otherwise be the case if all costs were incorporated in the selling price of the product.

In short, in cases where social costs of production exceed private costs, production is usually carried out in excess of the quantum of production that would be socially optimal.

Another example of production diseconomies can be seen in the case of an industrial production activity in which occupational or safety safeguards are lacking and workers frequently experience unwarranted injury resulting in the need for medical treatment or disability payments as compensation. If firms were required to

provide additional safeguards for the benefits of workers, costs of production would rise, which in turn would result in increased selling prices and consequently reduced sales and production output.

Failure by Government to do anything in such cases amounts to advocating an implicit policy of subsidy to industry. In such cases, the social costs are borne by the community or workers associated with the industry or firm in question. These costs can rightfully be viewed as an indirect tax on the community residents and workers. However, there are a number of actions Government can take, including the following:

- Pass a law requiring firms and industries to provide proper equipment and policies that stop pollution and/or unwarranted industrial accidents under penalties of fines, revocation of licensure to produce, etc.

- In the case of industrial injury, provide free medical care to workers and establish occupational accident and disability funds to compensate individuals injured on the job.

- Take responsibility for cleaning-up the environment, either through direct activity or paying private sector entities to provide needed services, i.e., treating streams and lakes for pollution or otherwise providing safe and pure water. The problem of treating air which has been contaminated is more difficult.

- Laws that prohibit, limit and/or tax health hazards (such as alcohol and cigarettes) to discourage consumption and generate revenues to help defray costs of future health care services.

- Subsidize the private firms or industries involved to make the investment necessary to remove the problem.

The first option above involves enforcement and thereby inspection and control activities on the part of Government. It in effect forces firms and industries to "internalize" the social costs previously disregarded and incorporate them into the cost structures of the firms and industries involved. The expected result is higher prices for output, and perhaps lower sales and production. Often enormous investment is required.

Examples include the construction of "mile high smoke stacks" which may simply transport pollution to another community or country thereby shifting the social costs to neighbors or the installation of "scrubbers" which remove contaminates prior to passing by-products into the atmosphere. These measures may be undesirable in the case of a developing country struggling to develop either cost competitive import substitution or export firms/industries.

The second option which pertains to occupational disability is the one most often favored by nations of the world. Such policies usually involve levying a wage based tax on both employees and workers which is directed into a fund that could be administered by qualified contractors under the auspices of Government. Problems usually encountered with this approach can involve disagreements as to the appropriate levels of tax contributions, and the size and payout periods of disability benefits. Such an approach, however, only provides redress to occupational related injury and does not address any other case in which social costs exceed private costs, i.e., pollution and other such cases.

The third option is an approach often taken by many countries and has the virtue of involving substantial private sector participation. A combination of levying taxes on the polluting firms and industries, but allowing them the option of cleaning up their production process and thus avoid the tax, or using the tax proceeds to reimburse private sector firms who specialize in such activities are approaches that many nations have followed during recent decades.

The fourth option encourages the use of economic sanctions and incentives:

- to encourage greater personal responsibility for their own well being and lifestyle;
- to assign a greater portion of the costs of treating people with self inflicted health problems to prevention of disease;
- offers the potential for a new source of fiscal strength.

The fifth option is also very popular in the case of nations that are struggling to become or remain competitive in the international market place and is often used in combination with the third option described immediately above.

There are some cases in which production confers social benefits in excess of the actual private costs and prices paid by consumers. Examples include the construction of feeder railways, spur lines, access and marketing roads and large volume of usage of social services like electricity which lowers operating costs to all consumers: industrial, commercial and residential users, etc. In these cases Government's role is frequently being defined to be to encourage these activities through various forms of tax relief and direct subsidy.

These situations arise when one individual or group of individuals pay a price for a unit of a commodity that represents the value of the private benefit it confers to them, but additional benefits are conferred indirectly to others who do not consume or pay for units of the commodity themselves. A good example is immunization. The fact that one individual is immunized against polio or small pox confers a benefit to that individual because, assuming no adverse reaction, the individual will not contract that particular disease. However, others

benefit from that one individual's purchase and consumption of a small pox immunization by virtue of the fact that the person immunized also can not be a carrier of small pox and is incapable of transmitting it to others. One person's purchase of an immunization constitutes a small break in the link of the transmission process.

It is well known among epidemiologists that it is not necessary to immunize or treat every single member of a population in order to dramatically reduce or even eradicate a communicable disease. It is usually only necessary to treat or immunize a substantial proportion of the population at risk so as to effectively interrupt the transmission process and to isolate and treat the remaining cases. From that point forward, it should only be necessary to: 1) maintain surveillance, 2) to guard against external transmission, and 3) to quickly isolate and treat new cases as they arise and to reimmunize periodically when necessary. In such cases, those who do not purchase an immunization receive what economists refer to as a "free ride," because of the purchase and consumption activities of others. The "free riders" may be unaware that they are benefiting from the consumption of others and are indirectly receiving a consumption externality.

In cases where there exist substantial consumption externalities conferring benefits on non-consumers, leaving production and consumption purely in the hands of the private sector is likely to result in less than social optimal production, distribution and consumption of the commodities in question, than if Government plays an active role. The problem is that individual consumers who purchase the commodities in question naturally are unwilling to pay a price equal to the private benefit which they receive plus the social benefit that others receive as an external consumption economy. In addition, those receiving the indirect benefit may be completely unaware of it, hence are unwilling to pay anything. Thus, private sector agencies have reduced motivation to produce very large quantities of these items, since the market is "thin."

The appropriate role of Government is to see that these commodities are produced and consumed in socially optimal quantities. The usual methods or options apply: pass laws requiring production and consumption; providing private producer and consumer subsidies; or direct production through public agencies, i.e., the Ministry of Health. In all cases, Government must play a strong oversight role in assuring that proper quantities are produced and consumed and that the commodities are of appropriate quality. In most countries, Governments employ law and direct production as positive roles to ensure socially optimal production, distribution and consumption.

3. Health Care as a Basic Human Need and a Right Rather than a Privilege.

"He who has health has hope." All nations of the world have accepted the concept that access to health care is a right and not a privilege. With the right, however, should come some "compact" that the costs of lifestyle induced illness represent a burden that should be shared by the individual and the collective society. Advocates of the concept of "health as a right" and not a privilege are emphasizing that health care should not be the exclusive consumption province of the wealthy and high income earners of a nation. Yet all nations, even the richest, recognize that the right to receive health care cannot be unlimited. This debate is linked to ethical questions of which types of physicians will be supportive of such endeavors, and which services are the most cost effective interventions to yield optimal health gain.

Advances in medical technology have made it possible to employ extremely sophisticated diagnostic and therapeutic tests and treatments, and even to replace defective bodily organs with artificial devices or with transplants from living or deceased persons. Many of these procedures, while technically possible, are extremely costly and are beyond the resource capacity of even the richest nations to afford to supply in unlimited quantities. Thus the concept of "health as a right" must be interpreted within the constraints of an individual nation's available resources and the Government's willingness to promulgate policies that may be good longer term, but less politically attractive in the short term.

The concept of health as a right is essentially an assertion of a value judgment concerning equity, not an assertion of entitlement to unlimited consumption of health services.

Health is no different from any other basic need including access to food, shelter, and clothing. In short, access to health care has come to be regarded as the fourth basic necessity of life, (life, liberty and the pursuit of happiness and well being) but provision of all four necessities must necessarily be limited in absolute quantities to levels that are within a nation's resource capacity to supply.

Of equal importance is for Government to determine what is the ***level of the basic package*** of comprehensive health services that can and/or should be made accessible to all, regardless of place of work, residence, and levels of income and wealth, that is consistent with the level of national resources available at each stage of its development. Also, Government must assist in determining how to produce and distribute the basic package of services optimally. As a nation's economy grows, its capacity to expand the basic comprehensive package of health services will increase.

As will be elaborated later, there is reason to believe that if the production and distribution of health services is left entirely to the private sector, medical resources including doctors, dentists, nurses and hospitals and clinics will probably disproportionately become concentrated in the highly urban and affluent areas of a country. The

pursuit of profit will motivate producers to cater to the affluent sector of the society which tends to be concentrated in urban centers, leaving the not so affluent largely inner-urban and rural populations of the country without access to needed medical services. Without some level of Government oversight and measurable performance targets, some providers may jump in to serve or "skim" just the cream.

Thus unguided, unregulated, or undisciplined private medical sector production and distribution is generally found to be inconsistent with the principle of equity embodied in the concept of accessibility to health services as a right to all and not a privilege and with the concept that health care at affordable levels is the fourth basic necessity of life. For the converse, however, over regulation can stifle private sector creativity and enthusiasm to proceed.

The new Russian Federalism in health must explore a reasonable balance of public and private sector actions and investments for 21st Century health gain.

4. Health Services as an Investment in Human Capital.

Part of the reason health is regarded as a basic necessity rests on relatively pure humanization considerations. However, there is also an economic consideration that must be taken into account in connection with determining the optimal production and distribution of health services, namely, that health services are needed to maintain and improve the quality of the workforce of a nation.

The productive potential of a nation is only partially measured by the quantities of labor and capital (both endowed and created). In addition to the quantities of labor and capital available, the age and condition of these factors of production are important. Health services of both a preventive and a curative nature are necessary to maintaining the stock of human capital represented by the labor force in each individual nation.

Through lowering disease morbidity, the annual days of lost production in the house and in the agricultural, industrial and commercial sectors, and the numbers of days lost from school are reduced, thereby increasing the productive potential of the nation. Similarly, averting premature mortality, particularly during the prime years of a working life, elevates and sustains the productivity of a nation and reduces the dependency ratio between working and non-working segments of the population.

5. Consumer Ignorance, Price as an Indicator of Quality, the Relative Inelasticity of Demand for Curative Medical Services, and Supply Creates Demand.

The delivery of modern curative medical services is a very personal, but essentially technical activity. Modern medicine is increasingly highly complex and scientific.

Consumers still have only passing familiarity with medical concepts, terms of reference, language and the technology employed in the practice of medicine. Consumers of medical services often present themselves for treatment under circumstances of great pain, anxiety, fear and apprehension. Under such circumstances, consumers are likely to be unable to make rational judgments and decisions. The same is true of friends and members of the family. Health professionals, particularly doctors, have an enormous social responsibility and are a very special type of individual. They also are in a commanding role in directing the allocation of scarce resources which are used, in combination with their skills, to produce improvements, hopefully cure, in the condition of patients who are ill.

Under the conditions which patients present themselves for receipt of curative medical services, they are almost completely receptive to the medical direction and advice given by health professionals. Therefore, they tend to be less sensitive to prices or costs of medical treatment.

Economists use a measure of the responsiveness of changes in the quantities purchased in relation to the percentage change in price. This measure is called the ***price elasticity of demand***. The less sensitive consumers are to changes in prices, the less the absolute value of the price elasticity of demand. Commodities for which consumers are relatively price insensitive exhibit price elasticities of demand which are less than unity in absolute value. These are said to be ***price inelastic***. (The algebraic sign of elasticity coefficient in the case of "normal goods" is generally negative, because ***price and quantity*** demanded are inversely related).

Empirical studies in most countries of the world have now revealed that the price elasticity of demand for curative medical services is inelastic. Part of the explanation offered for this phenomenon is that often there are few substitutes available for curative medical services known at the time of illness. Consumers are prone to consume the services doctors or other health professionals direct and worry about paying for them later. Also, price is often interpreted by consumers as an index of the "power" or the quality of the treatment. In particular, the higher the fees doctors charge, the greater skill many consumers believe the doctor possesses.

The implication of vast consumer ignorance and the relative price inelasticity of demand for curative services is that doctors are in a very strategic position to take economic advantage of patients. In the private medical sector practice setting, the economic temptation of inappropriate care and profit can place doctors in constant conflict with medical professional ethics. Experiences of the world suggest that many, but certainly not all, doctors tend to overtreat and overprescribe, if they are rewarded by profit in doing so.

Another implication is that because of consumers ignorance and that commanding authority role of doctors, an increase in the supply of private sector medical services available tends to generate their utilization by consumers, i.e., "supply tends to create demand". Increasing the numbers of private doctors, hospital beds, other cadres of health manpower and medical equipment, virtually assures at least their modest utilization. This is because it is generally in the private medical sector's interest to at least recover the costs of investment and possibly make profit. Doctors are at the center of the stage in all of this since in most countries they direct the quantity and types of medical services each patient receives.

6. Rising Consumers Expectations and the Implications of Advances in Medical Technology.

Although often uninformed concerning details of the technical aspects of the practice of medicine, consumers are generally aware of the latest advances in medical treatment and diagnosis. This is because this information is widely disseminated in the media. Knowledge of the availability of new and superior methods of diagnosis and treatment raises consumer expectations concerning the potential benefits of receiving medical services. Knowledge of medical advances whets the appetite of consumers for more and more expensive medical services.

However, advances in medical technology also whet the appetite of health professionals as well. Professionals in any field want to be modern, up to date and able to have access to and to apply the latest technologies available to their profession. This is all very natural and understandable. However, certain problems exist in connection with advances in medical technology.

First, not all the so-called advances in medical treatment and diagnosis are of proven value over existing alternatives which are of proven effectiveness. Major revision in thinking often occurs in regard to "state of the art" therapies and diagnostic tools and procedures. Studies in the US and other so called advanced countries often show very little positive advantages of new technologies over older technologies of proven value. Examples of this are too numerous to list here, but a few examples are instructive.

- Cortisone therapy for arthritis
- Radical mastectomy for cancer of the breast
- Heart by-pass surgery.

This is not to say that all new procedures and tools have no value. Rather, the margin of effectiveness is now believed to be less than thought originally. Second, advances in medical technology are rarely cost saving. Instead, they usually require the acquisition of extremely costly equipment, specially trained technicians to operate and to maintain the new equipment and specialized training for the doctors who are going to use these procedures. In short, advances in medical technology are usually extremely expensive. Often the marginal increment of benefit that they provide to patients, even when used with the utmost selectivity, can be less than the marginal cost required in their application and use.

Even worse, new medical technologies are seldom used selectively, rather they tend to proliferate throughout health services delivery systems, are widely duplicated, and tend to be used so indiscriminately as to border on abuse, particularly in the case of private medical sectors which are unregulated.

In view of these considerations, it is important that the pace at which advances in medical technology are adopted and introduced into a country be carefully monitored and regulated so as to adopt only those technologies that are of greatest value and effectiveness. Careful monitoring and supervision of the use of these techniques and procedures is needed in order to avoid wasteful duplication within and between the public and private curative medical sectors. Ways of sharing access to and utilization of expensive treatment and diagnostic facilities and centers can be worked out cooperatively between public and private health sector health programs and facilities. Finally, it is important that consumers be advised of the nature of new medical technologies that are introduced into the country and educated as to the rationale for their deployment and use in order to enhance their understanding and cooperation in the utilization of these costly facilities and procedures.

7. Curative Medical Services as Luxury or Superior Goods and the Relative Inelasticity of the Supply of Curative Medical Services.

Economists define “luxury” or “superior” commodities as goods and services for which consumers are willing to increase their consumption in greater proportion then the increase in their real incomes. The income elasticity of demand is measured as the ratio of a proportionate change in quantity demanded to a proportionate increase in real income.

An empirically measured coefficient greater than unity is sufficient to classify a commodity as a superior or luxury good. The implication of this is that in the case of luxury or superior goods, when consumers experience say a 30 percent increase in real income, they tend to increase their consumption of the commodity by more than 30 percent.

Economists define ***elasticity of supply*** as the ratio of a proportionate change in quantity supplied to a proportionate change in price. An empirically measured coefficient less than unity is sufficient to classify a commodity as being "supply inelastic". The sense of this is that if price were increased by say 30 percent, in the case of inelastic supply the response of suppliers would be to make less those 30 percent more quantity of output available in the market place.

In those countries in which empirical estimates have been made, in both less and more developed countries, the income elasticity of demand has been measured to be greater than unity signifying that curative medical services are luxury or superior goods.

Also, in countries for which empirical studies have been conducted, the supply of curative medical services is inelastic. The implication of these two empirical facts are extremely significant.

First, it suggests that if more money is made available to consumers (i.e. consumers experience an increase in real income or purchasing power), they could attempt to increase the quantities of medical services consumed in greater proportion to the increase in the additional funds available. In short, the demand for medical services increases, in proportion greater than the increase in funds available. In the market place, an increase in demand, with no change in supply will cause prices to rise.

Second, an increase in the price of medical services will bring about an increase in the quantity supplied. However, when supply is inelastic, as is the case of most curative medical services, the increase in the quantity of medical services supplied can be less than the proportionate increase in price.

The consequences of all of these are that as the demand for medical services increases, prices rise, but the quantity of medical services supplied increases less proportionately than the increase in prices. Consumers are frustrated by the fact that they fail to receive all the medical services that they anticipated and the prices of medical services are higher than what they were before. The fact that suppliers enjoy higher prices, but only increase quantities supplied less than proportional to the increase in prices, may mean that the prices per unit of medical services supplied increase, resulting in an increase in the incomes of the suppliers of medical services.

In short, significant increases in financing of health care to be delivered by an unfettered, private medical sector is likely to result in escalating health services delivery prices, a modest increase in supply and possibly an unwarranted transfer of wealth to the private medical sector.

These problems are exacerbated by the private medical sector penchant to rapidly adopt advanced but extremely expensive medical technologies which tend to further escalate the rise in medical prices, but only modestly increase the quantity and quality of curative services supplied. In addition, some medical suppliers exploit their

patients by over prescribing drugs, diagnostic tests and expensive medical procedures.

A great deal of the explanation of the large proportion of national income that Americans spend on health care is provided by the fact that the U.S has a relatively high income, the supply of medical services is inelastic, a large proportion of the population that is aged (Medicare) and that deliberate political decisions were made to make it possible for the aged and the medically disabled and indigent (Medicaid) to receive highly sophisticated and expensive medical services regardless of income. Some cross-national expenditure profits are appended to this discussion paper.

8. Interconnections and Interactions Between the Private and Public Medical Sectors.

Often public officials and members of the private sector believe that there are no significant interconnections or interactions between the public and private medical sectors. Indeed, some people argue that it is undesirable if any interconnections happen to exist or were established. Since the two sectors essentially are different, it is argued that they in fact are independent and should remain that way. Usually it is members of the private medical sector who make the strongest case for the independence of the public and private medical sectors. By claiming that the two sectors are completely independent, private medical sector entrepreneurs hope to avoid Government regulation.

Many countries of the world have learned a rather bitter lesson in failing to recognize that it is inevitable that interconnections as well as interactions exist between the public and private medical sectors when these sectors exist within the same country. Failure to recognize their existence of significant interconnection and interaction between the public and private medical sectors can lead to serious problems.

These problems are extremely difficult to correct once they have reached significant levels. Some of the more important interconnections and interactions often existing between the public and private medical sectors are discussed below.

The first important connection between the public and private health sectors is that the bulk of health manpower existing in the two sectors are often trained by the same medical educational institutions that exist within the nation. To the extent that medical education is predominately conducted by the public sector and medical students are charged below full cost, or to the extent there is an element of public subsidy to private medical educational institutions, there is an element of public subsidy in the cost of training private sector health manpower.

A second important interconnection that exists between the public and private medical sectors is that the two sectors share the

fruits of medical research and advances in medical technology. To the extent that these developments are funded from public funds, there is a direct subsidy to the private medical sector.

A third major interconnection existing between the public and private medical sectors concerns the fact that these two sectors often are in direct competition with each other for patient revenues. It is often stated that the two sectors are complementary, because the private sector treats many patients thus relieving the public sector of part of the total population's burden of treatment.

However, in a situation in which the public sector charges user fees which are graduated upwards according to class of accommodation reflecting the ability of patients to pay, selective treatment on the part of the private medical sector of the more affluent segment of the patient population could divert funds from the public medical sector needed to provide services which are made available to all patients non-selectively. In this sense, it is clear that the two sectors are in direct competition for funds needed to operate their respective systems.

A fourth major interconnection between the two sectors is that the two sectors are in direct competition for patients. Patients are encouraged to choose between the two sectors. However, the basis on which consumers make such choices, in large measure, are made in consideration of price, convenience and perception of quality of medical care provided.

Consumers have generally not been very good at correctly judging quality of medical care, as stated above. They can be led to believe that personal amenities and convenience as well as higher prices are indicators of high quality even if differences in the quality of pure medical service do not exist.

However the quality of medical care offered in the private medical sector as perceived by patients, as well as prices and levels of convenience and amenity are critical standards with which the public medical sector is confronted and must strive to equal or for which compensation must be offered.

The level of medical technology represents a fifth major interconnection between the public and the private medical sectors. Just as the public and private medical sectors are in competition for patients and revenues in terms of patients perception of quality and amenities, the two sectors are also apt to be in competition for patients and revenues in terms of the offering of advanced medical technologies. The level of medical technology offered in the private medical sector also represents a standard that the public medical sector must equal or for which compensation must be made.

A sixth important interconnection that exists between the public and the private medical sector concerns the salaries and levels of earnings existing between the two sectors. The levels of salaries and earnings of cadres of health manpower employed in the private medical sector also represent a critical standard or margin which the

public medical sector must equal or for which compensation must be made in order to retain staff in the public sector.

The importance of recognizing the existence of these interconnections is that it is critical in formulating public policy to be able to anticipate the implications of the introduction of any significant policy initiatives that may be undertaken. This is particularly the case in connection with the possible adoption of third party reimbursement as a means of furthering the privatization of the health services delivery sector.

The interactions and interconnections briefly described above are dynamic and are changing over time. Certain trends are ongoing and significant policy initiatives are seldom neutral. Anything that is done that alters the standard or critical margins of difference between the private and public medical sectors will have direct implications for altering the balance of service provision between these two sectors. Perhaps just as importantly, policy initiatives which have as their objectives the alternation of the balance of service provision between the private and public medical sectors are likely to have a significant and often undesirable impact on the overall cost and price structure, the level of quality of health care and the diffusion of technology throughout the entire health services delivery system.

For example, other things equal, anything that makes the private sector more attractive to patients, say through making it possible to improve the quality of care in the private medical sector, will attract more patients, revenues and health professionals to the private medical sector.

More than likely these changes will occur at the expense of the public medical sector (lost patients, revenues, health manpower, etc.), unless appropriate compensations are made. However upon making such compensations, dynamic forces are brought into play that may ultimately result in restoring the original balance of service provision that previously existed within the entire health services delivery system, but with the result that both the private and public medical sectors are forced to operate with a higher cost and price structure than before, to the disadvantage of both Government and consumers.

Therefore, in appraising the desirability or undesirability of any specific policy initiative, it is important to assess the probable consequences of its adoption with an eye towards the likely implications of possible interactions that exist between the private and public medical sectors. It also is very important for there to be substantial cooperation and coordination between the private and public medical sectors. Clearly, Government should have access to data reflecting pertinent features, activities and developments occurring in the private medical sector. It is only when information is shared, that trust can be established.

9. Third Party Reimbursement.

Some rather special problems are presented to health services delivery systems when third party reimbursement schemes are introduced. Third party reimbursement exists when an agency, either private sector or public sector, becomes involved in paying the costs of medical services rendered on behalf of consumers while not being itself a supplier or consumer of the medical services consumed.

The two principal parties to a medical service transaction are the supplier and the consumer of the medical services exchanged. The entry of an agency which is neither a supplier nor a consumer of the services and which only has responsibility for paying for the costs of the services exchanged is a third party to the exchange of services. Since the sole function of such an agency is to make reimbursement on behalf of one or the other of the two principal parties, such agencies are referred to as ***third party reimbursement agencies***. These agencies indemnify those who are covered against a portion of the financial risk that is involved in the event of illness for which patients must pay all or part of the costs of treatment out-of-pocket in the absence of insurance or other third party coverage. In some literature, these types of agencies are referred to as "indirect" suppliers of medical services.

Note that Government as the financing agent for the public health services delivery system is not a third party reimbursement agency. This is because in this case Government is directly involved in the actual supply of medical services and thus is a principal party in the exchange of medical services, as well as being a financier of health care delivery. In some writings, agencies of Government such as Ministries of Health, Social Security Systems which operate hospitals, clinics, etc. are referred to as "direct" suppliers of medical services in contrast to cases in which such agencies play a sole role as a reimbursement agency.

Examples of third party reimbursement agencies are private health insurance companies and Government organizations in the case of industrial related accidents. Up to now, third party reimbursement in Eastern Europe has operated on a comparatively small scale.

Private health insurance companies cover only a small portion of the population and the medical reimbursement activities have been comparatively modest.

Private health insurance involves a contractual relationship between a private company which will assume risk for the financial consequences of events of illness arising on the part of policy holders. Policy holders may be individuals or groups which pay a negotiated premium for the right to receive financial reimbursement to defray the costs of medical treatment required in cases of specified types and episodes of illness. The private health insurance company is a third

party reimbursement agency, since it is neither a direct provider or consumer of health services.

Private health insurance companies provide assumption of and risk pooling services to policy holders. In return for these services, private insurance companies charge a premium that covers the predicted benefit payment stream to policy holders, plus an amount necessary to cover the cost of administration, plus an amount necessary to cover any salaries and commissions to salesmen and possibly an additional amount to provide an underwriting profit in the case of profit seeking companies.

Note that in addition to underwriting profits, private insurance companies typically seek to earn substantial profits on other investments. These profits arise from the fact that the stream of premium payments is fairly regular, either paid on a monthly or yearly basis, but benefit disbursements are more random and depend on the incidence of events of illness in the insured population. Since the incidence of illness is unpredictable the benefit payments must be sufficiently

large to maintain a reserve of funds to be available in the event of wide spread endemic illness that may occur in the insured population. Provision is made in premium billings purposefully to accumulate reserve funds, which insurance companies typically invest in financial interest bearing assets. Since these assets earn interest, this income constitutes additional earning to insurance companies, and often constitute a very large source of earnings.

Thus the total earnings of a private insurance company net of expenses and benefits paid out consist of a total of underwriting profits plus net earnings on investments. The results of interviews with insurance executives can fail to provide an indication of what the total percentage of profit on insurance activities is typical in the country.

Private health insurance costs per unit can be rather expensive compared to social insurance schemes, in as far as substantial expenses are typically incurred in the form of sales commissions and advertising and promotion expenses. In addition, while many of these firms are not profit seeking, substantial surpluses are in fact collected and maintained by these firms in the form of reserves. Clearly in the case of profit seeking firms, policy holders on the average would receive a pay out benefit only roughly equal to 60% of the value of premiums paid. In principle, this ratio can be improved substantially if insurance were provided through social mechanisms like a compulsory national health insurance scheme which would eliminate both profit as well as selling commissions and promotional expenses.

A second consideration that is important in this context is that private health insurance companies need to offer policies that help operate the State in a prudent stewardship role. This is because underwriting profits objectives are established as a percentage of total

costs. Any increases in cost are usually passed on to the policy holders in the form of higher premiums which the insurance company will maintain are "uncontrollable". With such increase, insurance companies then add the same percentage of underwriting profits margin and thus the result is a larger total profit occurring to the insurance company. In fact, the incentive exists for the insurance company not to attempt to control costs in the ultimate interest of earning a higher total profit.

Finally it should be noted that ***risk pooling*** is directly proportional to the size of the population insured and that administrative costs tend to be inversely related to the magnitude of premiums collected which, in turn, is directly related to the number of persons insured. The existence of a large number of private health insurance companies has the virtue of providing competition which tends to drive down premium rates. However, a social cost is incurred in having a large number of comparatively small private insurance organizations. This cost derives from the fact that administrative costs per policy holder in each of these firms is higher, and the risk pooling that each firm can provide is lower than that which will be the case if health insurance were provided through a single consolidated agency that would provide coverage to all or nearly all a nation's population.

Therefore, on the grounds of operational efficiency, as well as risk pooling a case may be rather compelling to favor national social insurance schemes over private health insurance sector which currently in Eastern European countries is comprised of a comparatively small number of rather small firms. A balance of public and private sector roles is needed.

Several persons have suggested the expansion of new forms of "third party" payment to providers is needed that offer incentives for cost effectiveness and access to care. Indeed, the study of possible new forms of health insurance schemes should be a part of future policy debates. Particular interest has been expressed in connection with the possible role of ***health financing*** in furthering the role of privatization and in the more cost effective delivery of medical services.

The introduction of third party reimbursement influences the behavior of both health services providers and consumers. Caution is again warranted. The introduction of third party reimbursement introduces an element of impersonality into the provider/consumer relationship in that these two principal parties no longer have to consider full financial consequences of their decisions. Financial responsibility, at least partially, is assumed by a third party.

The third party payer has a primary responsibility to maintain the solvency of its operations. In doing so, the agency has the option of either attempting to hold down medical treatment costs or increasing sources of revenues, for example, increasing tax assessments in the case of public sponsored reimbursement agencies or raising subscription rates or premiums in the case of private sector reimbursement agencies. Not being directly involved in the decision

concerning the medical resources to be consumed in the course of medical treatment, it is difficult for third party payers to monitor and thus exercise control over costs. It is easier for a third party payer to work on increasing revenues when costs rise than to attempt to lower or contain costs.

When consumers and providers are relieved of financial responsibility in connection with the utilization of medical resources consumed at the time medical services are needed, neither have much incentive to economize on their use. Consumers want all the medical resources that could be applied with some degree of medical effectiveness to improve their health status. Even in the absence of profit motives, health professionals have an incentive to order the application of all medical resources that conceivably could bring about a marginal improvement in the health status of the patients in their care. It is only by doing so that health professionals feel that they are doing their best in caring for their patients.

In such cases, technological imperatives tend to prevail over those which are economic. The economic imperative that is overridden in this instance is the principle that in order to achieve an optimal allocation of resources, they must be applied to the point at which marginal social benefit equals marginal social cost. Both consumers and health professionals have an incentive to apply medical resources to the point at which marginal social benefit is zero, which is a point beyond where marginal social benefit equals marginal social cost.

The extra medical resources that are consumed as a result of the over utilization of health resources in the circumstances just described deprive society of the opportunity to consume other goods and services yielding higher social benefits than those yielded by the last increment of medical services consumed. In this case the "opportunity costs", the social benefit that society loses in terms of foregone production, are greater than the actual benefits received from devoting resources to the production of medical services rather than to the production of some other goods or services as an alternative.

Clearly when health professionals operate for profit, there is incentive for them, particularly doctors who are in the most commanding role in directing the flow of medical resources, to take advantage of consumers even in the absence of third party payers and to "stretch" medical ethics and to over prescribe and treat (over-doctor) in the interests of making money. However doctors and other health professionals tend to meet some consumer resistance in cases where consumers must pay at least part of the cost of the medical resources required in the course of their treatment. Since the demand for health services is not wholly

In cases where consumer resistance to consume is high due to the particularly poor financial status of patients, doctors may choose to give services away free or substantially below cost. Hospitals may "write-off" a significant proportion of billings and charges in the name of charity. Traditionally, charity has played a very significant role in the delivery of medical services in all nations during the course of their history.

However with the introduction of new forms of third party reimbursement, consumer resistance to consume tends to diminish, if the consumer does not have to pay as high a fraction of the cost of medical services as before. In addition, health professionals no longer feel a social and ethical obligation to give away health services free or at below cost. In such circumstances consumers tend to be less resistant and even tend to be rather vocal in demanding the best medical care that is available and health professionals are more than eager to provide it.

Also health professionals are less reluctant to "over-doctor", since they feel that they are not taking advantage of the consumer with whom they are dealing personally and directly. Harm is only done to the third party paying agency which exists as an abstract entity in both the minds of consumers as well as in those of providers.

A paradox of human nature and thinking underlies all of this. Providers and consumers can easily comprehend that increases in the prices and quantities of medical services utilized will eventually force third party payers to either monitor costs more closely and restrict payments or to increase taxes, subscription rates or premium contributions, depending on the status of the third party payer. Yet, once payment has been depersonalized (providers and consumers are removed directly from the payment process) providers and consumers alike tend to supply and demand and to continue to supply and demand the "best and the most". The tendency to "over-consume" medical services as a result of third party reimbursement has been labeled "moral hazard" in American health economics literature (this behavior is similar to the careless way in which members of the general public tend to abuse public works which are built and maintained at tax payers expense).

One should also recognize that both a moral and an "ethical hazard" is presented on the supply side of the medical market place which motivates doctors and other health professionals to "oversupply" medical services as a result of the introduction of third party reimbursement.

10. Health Maintenance Organizations and Preferred Providers Organizations in Connection with Fee for Service, Private and Public Health Services Delivery Systems.

The question arises as to whether or not a nationalized health services delivery system or that a portion of a public or government health services delivery system which provides services at heavily subsidized prices is not subject to moral and ethical hazards of the sort discussed above. Clearly this is possible, since both consumers and suppliers have little incentive to economize on the utilization of medical resources. However, experience shows that there is less likelihood that these problems are as evident in the case of public sector delivery systems due to several factors.

First, the majority of public sector doctors and other health professionals are salaried and thus there is reduced financial motive to conflict with medical ethics and standards of medical practice.

Second, most public health systems are funded prospectively on an appropriation budgeting basis which allows little flexibility and thus little opportunity to expend medical resources lavishly. Resources are kept "tight" and rationing of resources is performed by nonprice means, i.e., by forcing patients to wait in long queues or to remain without services for periods of time which admittedly are sometimes distressing to providers and consumers alike.

Third, such systems, at least initially, are often based on a strong civil service career structure that instills pride, prestige and stature to health professionals which promotes high standards of medical practice and respect in the eyes of patients.

When the positive elements of public health care delivery systems described immediately above slacken or are absent, public health systems tend to degenerate. In almost all cases, such systems tend to be underfunded, particularly on recurrent account, relative to what consumers and providers would like. Even when funding is adequate, such systems lack incentive for managerial efficiency and tend to render a type of health care that is highly impersonal. Patients tend to be relegated a low priority relative to adherence to policies, regulations and procedures which often are rigid. Such systems usually provide little by way of personal amenity, and opportunity for creativity and ingenuity.

There is always a class of patients who object to all of this more strongly than others, particularly to long waiting time and low level of amenity. These are people who can afford to pay more than others either by virtue of wealth and income status or special insurance or privilege accorded by employment status (e.g., civil servants). Often the public health services delivery system falls behind elements of the private medical sector in terms of quality of care and amenity.

This may be due to underfunding of the public delivery system by Government as the result of periods of economic adversity during which health tends to receive a reduced priority. It also may be due to a rapid rise in incomes or privilege on the part of certain population segments who patronize the private medical sector giving it revenues

with which it rapidly improves quality of services and personal amenities.

The fee for service private medical sector in almost all countries exists as an alternative to the public health services delivery system. To the extent that the private fee for service sector is not regulated, however, and it will tend to serve the relatively high income segments of the population and "skim the cream" of the medical market place. However there are other private sector institutional alternatives to strict fee for service private practice, i.e., HMOs and PPOs.

An HMO is an organized health services delivery sub-system within the private medical sector that has developed in the US as a viable alternative to private sector fee for service medical practice. It is an organization which sells entitlement to specified medical services on a prepayment basis. Subscribers or enrollees pay a monthly or annual subscription fee which entitles them to the specified service. Doctors associated with hospitals and other facilities making up the service provision element of the organization may be paid on a salary, fee for service or some combination of these. The HMO has a centralized management plan group which administers the organization and handles marketing, accounting, and other business aspects of the organization activities. The owners of the organization may be businessmen, doctors or members of the general public.

A principal feature of HMOs that differentiates them from group practices who also may or may not own or have a contractual relationship (leasing arrangement) with a hospital is that the HMO's revenue stream is fixed by the number of subscribers enrolled in the plan and the subscription rate. (Subscription rates may be rated individually based on age, sex, size of family, etc., or on a community rating or other group basis just like in the case of private or other health insurance).

A second principal feature is that the HMO contractually is obligated to supply all the medical services to which all its enrollees are entitled and need, regardless of the cost implications. If revenues for a given year exceed costs, the owners of the organization earn a profit. However, if revenues are below costs due to unpredicted levels of disease incidence or poor management, the organization suffers a financial loss.

In essence the unique characteristic of HMOs by comparison with group practices and third party payers is that HMOs assume financial risk as a principal party to the exchange of medical services, i.e., as a provider agency. HMOs assume risk just like health insurance firms, but also are direct providers of medical services.

The term "health maintenance organization" was coined in recognition of the fact that given the fixed nature of the revenue stream to the HMO, its profitability is maximized when service utilization is minimized. Thus HMOs would appear to have great

incentive to keep their patients as healthy as possible, i.e., to maintain the health of their subscribers. It was argued that HMOs would place great emphasis on health education, illness prevention and health promotion activities in order to minimize the incidence of illness in their subscriber populations. However, this assumes that the dominant objective or motive of HMOs is to maximize profits.

In fact many HMOs appear to have objectives other than strict organizational profit maximization. Some providers, particularly doctors like the regular working hours provided by HMOs. Many doctors seek to maximize professional satisfaction which is facilitated by working in an organization that is well managed.

Many health professionals want to work in an environment in which maximum professional skills can be brought to bear in the treatment of each case in an atmosphere in which they feel that advantages are not being taken of consumers. Few doctors have a major commitment to health education and promotion and illness prevention, preferring to practice and further develop the clinical skills that originally attracted them to medicine in the first place. In cases in which doctors are associated with an HMO on a strict fee for services basis, individual desire for profit may motive them to attempt to practice the same "style" of medicine that they would if they were working in an individual practice. However, utilization and other types of peer review incorporated into HMO operations tend to blunt any such tendencies.

The evidence in the US is that, in general, HMOs tend to lower medical costs in comparison to strict fee for service medical practice. However analysis of the origin of cost saving with which HMOs are rightfully credited reveals that these savings principally stem from reduced rates of hospital admissions and not from an emphasis on "health maintenance".

Other characteristics need to be mentioned in connection with HMOs. They tend to accomplish risk pooling the larger the individual population of subscribers. They also tend to be rather tightly managed and incorporate substantial peer review policies and procedures and thus tend to maintain a uniform and high standard of medical practice.

Preferred Provider Organizations (PPOs) are quite different from HMOs. PPOs are organizations which provide a "middleman's" role in organizing providers into organizations which are willing to give a discount rate per procedure rendered to members of an organized population of health consumers. Consumers are often already organized in the sense that have an affiliation to an existing organization, e.g., they are employees of the same firm, belong to a large professional organization, union, etc. Basically, managers of PPOs attempt to facilitate the organization of groups of consumers who are looking to receive medical discounts and groups of providers who are willing to give medical discounts on the basis of an assured volume of business.

PPO managers facilitate the organization of consumer and provider groups, serve as the middlemen in negotiating agreed upon rates of discounts, play a strong service role in billing and charge activities and often provide utilization and review services, all for a management and promotional fee. However, PPOs do not assume any substantial financial risks.

The legal status of PPOs currently in the US is rather cloudy. It is the view of many legal authorities that PPOs should be liable for incidents of malpractice or negligence, or should be required to provide more utilization and quality assurance.

A second issue involves anti-trust and restraint of trade considerations. Basically, PPOs organize blocks of consumers and providers into a preferential pricing arrangement and accept little or no risk. Persons not belonging to the PPO group are "locked out" and cannot receive the same discounts on medical services or the patient volume that is offered to consumers and providers of the PPO.

To the extent that aggressive PPOs are able to collectivize large proportions of either the consumer or provider market in a given area, power is concentrated in the hands of the PPO group. The locking out of potential competitors, particularly of individual or groups of providers, can be regarded in some countries as an action in restraint of trade.

Finally, since the statistical data that are available suggest that some PPOs have had less success at containing costs than HMOs, many business firms, unions and other organizations who can rather directly control or influence their members are themselves taking the initiative in organizing groups of providers into HMOs, or are effectively "shopping" for medical discounts on behalf of their members. Employers, however, may also experience pressure from their workers to retain the greater "provider choice" of PPOs.

Some analysts argue that since the revenue stream of HMOs is relatively fixed or flat, profits are maximized when services delivered are minimized. To the extent that HMO's attempt to maximize organizational profits, there is incentive to under-treat, under-prescribe, and generally to "under-doctor". Thus, in the case of HMOs, quality assurance programs are needed to assure that cases are treated fully and properly, and that an adequate volume of medical services are provided to subscribers. Thus, the objective of quality assurance and utilization review programs in the case of HMOs is just the opposite of the objective of such programs in the case of monitoring fee for service providers.

Note that the basic elements of an HMO are a fixed revenue stream, an organized group of providers that is willing to accept financial risks in incurring the costs required in providing necessary treatments for a defined set of medical service needs, and a client population that agrees to contribute to the revenue stream flowing to the organization in return for the medical services supplied by the

provider group. In connection with all of this, the HMO assumes a significant proportion (or all if there are no user fees or service exclusions) of the financial risk to which its subscribers are exposed due to the possible event of illness, the treatment of which would require out of pocket costs in the absence of membership in the HMO or of third party insurance coverage. These responsibilities are all spelled out by private contracts between consumers, providers and those managing the HMO.

A nationalized public health services delivery system essentially incorporates all of these same elements through a social contract existing between Government and the aggregate population. The aggregate population may be viewed as consumers who pay taxes (some more than others to be sure) part of which may be viewed as premiums or subscription payments which are paid to the Treasury. Treasury, in turn, appropriates a budget constituting a fixed revenue stream which is allocated to the Ministry of Health as the health services provider group which in turn is obligated to provide defined services to the population as its social responsibility. In doing all of this, the Government bears a significant proportion (or all in the absence of the user fees and service exclusions) of financial risk on behalf of the entire population just as an HMO bears a significant proportion of financial risk on behalf of its enrollees.

In short, a nationalized health services delivery system correctly may be viewed as a national HMO. In the absence of a private medical sector, it may be viewed as a national monopoly HMO.

However, private sector HMOs are not mini nationalized public health services delivery systems. They are private sector, risk bearing health services provider organizations that are operated according to flexible and proven principles of business management and financial control. Because of these factors, they tend to be well managed and can be very cost efficient.

However, just like any other form of private sector medical practice, HMOs have no inherent or intrinsic obligation of broad social obligation in the sense with which public systems are invariably charged. While HMOs provide risk bearing and risk pooling benefits to their members, they can be and usually are very purposefully selective, whenever possible, in their choice of location and clientele. If not given direction and guidance, at least initially, they tend to cater to comparatively healthy and high income segments of the medical market place and "skim cream". They can fail to provide high medical services of uniform quality. HMOs are most effective in an environment which is highly competitive in which they can offer an added element of consumer choice as an alternative to other health services delivery systems, either public or private.

11. Some Dimensions of Financing in Connection with

Privatization.

Privatization conveniently can be viewed in at least two broad perspectives or dimensions. One such dimension is from the perspective of the side of health services delivery. From this perspective, judgments must be rendered concerning whether or not it makes sense to allow elements of the private non-medical or medical sector to supply certain services rather exclusively or optionally in specified cases. A second such dimension concerns the financing of insurance for needed medical services. From this perspective, judgments must be rendered concerning the desirability of relying exclusively on public or private sources of funds in financing the purchase and utilization of medical services.

Both of these dimensions have major importance in terms of the strategic directions for Russia's next generation health sector. Essentially, these two perspectives will shed light on the balance of service provision between the public and private medical sectors, and the distribution of the burden of cost sharing between the public and the individual citizen.

The federal and territorial budgets and quasi public or strictly private sector have alternative sources of funds for financing needed health protection, promotion and restoration services. Once examining the various recommendations that have been offered as concerns privatization and having selected the set of feasible policy options, final recommendations can be analyzed in terms of their implications with regard to these two major policy concerns: the balance of service provision and distribution of financial burden. Indeed these two issues should be incorporated in the criteria to be used in appraising the desirability of various privatization options that have arisen since Russia's landmark health reform decrees of 1991 and 1993.

These above factors suggest that Russia needs to consider a unique new mix of public and private actors in both (a) the organization and delivery of needed curative health services, and (b) the financing of needed protection, promotion and restoration services.